

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05077

5107 CERTIFICATE OF DEATH

Reg. Dist. No. 90

| | | | | | | | |
|---|----------------------------------|---|--|---|--|---|--|
| 1. PLACE OF DEATH o. COUNTY MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Cecil | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cecil Chesapeake City | | c. LENGTH OF STAY IN 1b 1 day | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North East Rural | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Morgan Nursing Home | | | | d. STREET ADDRESS 1 | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Myrtle Katherine Abrams | | | | 4. DATE OF DEATH Month Day Year May 11 1957 | | | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH Oct. 31, 1870 | | 9. AGE (In years last birthday) 86 yrs. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seamstress (retired) | | 10b. KIND OF BUSINESS OR INDUSTRY Seamstress | | 11. BIRTHPLACE (State or foreign country) North East Rural | | 12. CITIZEN OF WHAT COUNTRY? U.S. | |
| 13. FATHER'S NAME William Abrams | | | | 14. MOTHER'S MAIDEN NAME Talitha Janney | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO. 166-28-1942 | | 17. INFORMANT Ernest Abrams | | Address North East Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma, bronchial 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | INTERVAL BETWEEN ONSET AND DEATH unknown | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from April 23 , 19 57 , to May 11 , 19 57 , that I last saw the deceased alive on May 11 , 19 57 , and that death occurred at 8:15p M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 233 E. Main Street DATE SIGNED May 11, 1957 | | | | | | | |
| ACTUAL SIGNATURE S. Ralph Andrews, Jr. | | | | M.D. 233 E. Main Street | | | |
| PHYSICIAN'S NAME (Type) S. Ralph Andrews, Jr., M.D. | | | | Elkton, Maryland | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF May 15, 1957 | | 22c. NAME OF CEMETERY OR CREMATORY Bayer-Wick Co. | | 22d. LOCATION (City, town, or county) (State) North East Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE J. Earl Tyson | | | | ADDRESS Rising Sun, Md. | | 24a. REC'D BY REGISTRAR DATE 5/15/57 | |
| | | | | 24b. REGISTRAR'S SIGNATURE Mrs. Ralph Bass | | | |

BUREAU V. 81

MAY 15 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 5108 CERTIFICATE OF DEATH

05078

Reg. Dist. No. 96

| | | | | | | | |
|--|--|---|--|---|--|---|---|
| 1. PLACE OF DEATH a. COUNTY <u>Cecil</u> <u>MARYLAND</u> | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Perry Point</u> | | | | c. LENGTH OF STAY IN 1b <u>4yrs1mo8days</u> | | | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster</u> | | | | 06272 ✓ | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Veterans Administration Hospital</u> | | | | d. STREET ADDRESS <u>266 E. Main Street</u> | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) <u>SAMUEL</u> <u>WELLS</u> <u>BATR</u> | | | | 4. DATE OF DEATH Month <u>May</u> Day <u>15</u> Year <u>1957</u> | | | |
| 5. SEX <u>Male</u> | | 6. COLOR OR RACE <u>White</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 8. DATE OF BIRTH <u>February 3, 1894</u> | |
| 9. AGE (In years last birthday) <u>63</u> yrs. | | IF UNDER 1 YEAR Months <u> </u> Days <u> </u> | | IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u> | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Plumber</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Plumbing</u> | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | | | | | | |
| 13. FATHER'S NAME <u>SAMUEL P. BATR</u> | | | | 14. MOTHER'S MAIDEN NAME <u>MARY E. SLAYBAUGH</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> | | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>WW-I</u> | | 17. INFORMANT <u>Unknown</u> | | Address <u>Hospital Records, VAH., Perry Point, Md.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart Disease.</u> DUE TO (c) <u> </u> | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>24 hours</u> <u>Several years.</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. <u> </u> p. m. <u> </u> 19 <u> </u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>April 7, 1953</u> to <u>May 15, 1957</u> and that death occurred at <u>3:10 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>VA Hospital, Perry Point, Maryland</u> DATE SIGNED <u>5-15-57</u> | | | | | | | |
| ACTUAL SIGNATURE <u>Joseph Gruberger</u> | | | | M.D. <u>VA Hospital, Perry Point, Maryland</u> | | | |
| PHYSICIAN'S NAME (Type) <u>J. C. GRASBERGER, M.D., Acting Director Professional Services,</u> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u> | | 22b. DATE THEREOF <u>5-15-57</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Westminster Cemetery</u> | | 22d. LOCATION (City, town, or county) (State) <u>Westminster, Maryland</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>David W. Bankard</u> | | | | ADDRESS <u>H. BANKARD & SON, Westminster, Maryland</u> | | 24a. REC'D BY REGISTRAR DATE <u>5-15-57</u> | |
| | | | | 24b. REGISTRAR'S SIGNATURE <u>Irvin E. Doughty</u> | | | |

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - JUNE 1957

BUREAU V. 4

1957

RECEIVED

5109 CERTIFICATE OF DEATH

Reg. Dist. No.

90

| | | | |
|---|-------------------------------|--|---|
| 1. PLACE OF DEATH o. COUNTY <i>CECIL</i> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>MD.</i> b. COUNTY <i>CECIL</i> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>FREDRICKTOWN</i> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>FREDRICKTOWN</i> x2 | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | d. STREET ADDRESS <i>1</i> | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <i>JOHN WALMSLEY BARNABY</i> | | 4. DATE OF DEATH Month Day Year <i>MAY 20 1957</i> | |
| 5. SEX <i>M.</i> | 6. COLOR OR RACE <i>W.</i> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>SEPT. 7 1875</i> |
| 9. AGE (In years last birthday) <i>81</i> yrs. | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>SHIP JOINER</i> | | 10b. KIND OF BUSINESS OR INDUSTRY <i>SHIP</i> | |
| 11. BIRTHPLACE (State or foreign country) <i>MD.</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i> | |
| 13. FATHER'S NAME <i>JOHN BARNABY</i> | | 14. MOTHER'S MAIDEN NAME <i>MARGARET TEMPLETON</i> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT <i>MRS. CATHERINE BARNABY, FREDRICKTOWN MD.</i> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute congestive failure + vent. fibrillation</i> <i>420.0</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arteriosclerotic Heart Dis.</i> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Senility.</i> INTERVAL BETWEEN ONSET AND DEATH <i>8 hours</i> <i>years.</i> | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <i>1900</i> 19 <i>56</i> , to <i>May 20</i> 19 <i>57</i> , that I last saw the deceased alive on <i>May 20</i> 19 <i>57</i> , and that death occurred at <i>6:30</i> M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <i>Walace Chenkin MD. Cecilton, Md. 22 May 57</i> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i> | | | |
| 22b. DATE THEREOF <i>5/23/57</i> | | | |
| 22c. NAME OF CEMETERY OR CREMATORY <i>GEORGETOWN CEM.</i> | | | |
| 22d. LOCATION (City, town, or county) (State) <i>GEORGETOWN MD.</i> | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>Edward Fellows, Mullington M.</i> | | | |
| 24a. REC'D BY REGISTRAR <i>MAY 28 1957</i> | | | |
| 24b. REGISTRAR'S SIGNATURE <i>Mrs Ralph W. Lewis</i> | | | |

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CERTIFICATE OF DEATH

| | | | | | | | | | | | |
|----------------------------------|--|------------------------------------|--|------------------------------|--|------------------------------|--|----------------------------------|--|----------------------------------|--|
| 1. NAME OF DECEASED | | 2. SEX | | 3. AGE | | 4. DATE OF BIRTH | | 5. PLACE OF BIRTH | | 6. OCCUPATION | |
| 7. MARITAL STATUS | | 8. COLOR | | 9. RELIGION | | 10. EDUCATION | | 11. SOCIAL CLASS | | 12. DATE OF DEATH | |
| 13. PLACE OF DEATH | | 14. CAUSE OF DEATH | | 15. MANNER OF DEATH | | 16. PERIOD OF ILLNESS | | 17. PREVIOUS ILLNESS | | 18. SIGNATURE OF PHYSICIAN | |
| 19. SIGNATURE OF REGISTRAR | | 20. SIGNATURE OF WITNESS | | 21. SIGNATURE OF DECEASED | | 22. SIGNATURE OF NEXT OF KIN | | 23. SIGNATURE OF BURIAL OFFICIAL | | 24. SIGNATURE OF FUNERAL HOME | |
| 25. SIGNATURE OF CHURCH OFFICIAL | | 26. SIGNATURE OF CEMETERY OFFICIAL | | 27. SIGNATURE OF INTERVIEWER | | 28. SIGNATURE OF SUPERVISOR | | 29. SIGNATURE OF CLERK | | 30. SIGNATURE OF ASSISTANT CLERK | |

BUREAU V. S.

MAY 28 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

5110 CERTIFICATE OF DEATH

Reg. Dist. No.

91

| | | | |
|--|------------------------|--|--------------------------------|
| 1. PLACE OF DEATH a. COUNTY Cecil MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Md. b. COUNTY Cecil | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Charlestown | | c. LENGTH OF STAY IN 1b 2 weeks | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Morgan Nursing Home | | d. STREET ADDRESS | |
| 3. NAME OF DECEASED (Type or print) Alice Maude Beal | | 4. DATE OF DEATH Month May Day 26 Year 1957 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH Oct. 27, 1880 |
| 9. AGE (In years, lost birthday) 76 yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | |
| 11. BIRTHPLACE (State or foreign country) Maine | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Henry Allen | | 14. MOTHER'S MAIDEN NAME Emma Freeze | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT Leon E. Beal, Charlestown, Md | | Address | |

| | | |
|---|--|--|
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension (c) Arteriosclerosis | | INTERVAL BETWEEN ONSET AND DEATH 50 hrs 6 yrs 6 yrs + |
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| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 350X Paralysis Agitans | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
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|--|---|--|--------------------------------------|
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Hour a. m. p. m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |

| | | | |
|---|--|---|--|
| 21. I certify that I attended the deceased from Sept 1951, to 26 MAY 1957, that I last saw the deceased alive on 25 MAY 1957, and that death occurred at 1:45 PM, from the causes and on the date stated above. | | ADDRESS (Street, city or town, state) Elkhart, Ind. | |
| ACTUAL SIGNATURE George J. Kreis, Jr. M.D. | | DATE SIGNED 3/27/57 | |
| PHYSICIAN'S NAME (Type) George J. Kreis, Jr. | | | |

| | | | |
|--|-----------------------------|--|--|
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF 5-28-1957 | 22c. NAME OF CEMETERY OR CREMATORY Charlestown | 22d. LOCATION (City, town, or county) (State) Charlestown, Md. |
|--|-----------------------------|--|--|

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|--|--|---|
| 23. FUNERAL DIRECTOR'S SIGNATURE Leola Patterson-Lyon, Perryville, Md. | 24a. REC'D BY REGISTRAR DATE MAY 28/57 | 24b. REGISTRAR'S SIGNATURE Mrs. Ralph H. Ba |
|--|--|---|

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

1957

DECEASED

PLACE OF DEATH

BUREAU V. S.

MAY 29 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5111 CERTIFICATE OF DEATH

05081
91

Reg. Dist. No.

| | | | |
|---|---|---|---|
| 1. PLACE OF DEATH a. COUNTY Cecil MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Cecil | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chesapeake City | | c. LENGTH OF STAY IN 1b 2 weeks | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mprgan Nursing Home | | e. STREET ADDRESS 1 R. D. #4 | |
| 3. NAME OF DECEASED (Type or print) First Fannie Middle E. Last Calvert | | 4. DATE OF DEATH Month May Day 8 Year 19 57 | |
| 5. SEX F | 6. COLOR OR RACE W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Jan. 28, 1879 |
| 9. AGE (In years last birthday) yrs. 78 | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home | | 10b. KIND OF BUSINESS OR INDUSTRY House Work | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME Lynch | | 14. MOTHER'S MAIDEN NAME No Information | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT William Calvert, R. D. #1 Elkton, Md. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular renal disease 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | INTERVAL BETWEEN ONSET AND DEATH unknown | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | 20d. INJURY OCCURRED While Not while of work of work <input type="checkbox"/> <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from Sept. 18 , 19 56 , to May 8 , 19 57 , that I last saw the deceased alive on April 27 , 19 57 , and that death occurred at 8:45a M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 233 E. Main St., Elkton, Maryland DATE SIGNED 5/9/59 | | | |
| ACTUAL SIGNATURE S. Ralph Andrews, Jr. | | PHYSICIAN'S NAME (Type) S. Ralph Andrews, Jr., M.D. | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF May 10, 1957 | 22c. NAME OF CEMETERY OR CREMATORY Cherry Hill Cemetery | 22d. LOCATION (City, town, or county) (State) Cherry Hill Md. |
| 23. FUNERAL DIRECTOR'S SIGNATURE W. H. Hoppin | | 24a. REC'D BY REGISTRAR DATE 5/11/57 | 24b. REGISTRAR'S SIGNATURE J. P. Traylor |

BUREAU V. 8

75 13 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5112 CERTIFICATE OF DEATH

05082

Reg. Dist. No. 96

| | | | |
|---|---------------------------|---|------------------------------------|
| 1. PLACE OF DEATH a. COUNTY Cecil MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Port Deposit, Rural. | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X2 Port Deposit, Rural | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rt. 222 | | d. STREET ADDRESS 1 Rt. 222 | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Helen Louise Cameron | | 4. DATE OF DEATH Month Day Year May 18 1957 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Sept. 10, 1874 |
| 9. AGE (In years last birthday) 82 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife | | 10b. KIND OF BUSINESS OR INDUSTRY Own Home | |
| 11. BIRTHPLACE (State or foreign country) New York | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME George Shaad | | 14. MOTHER'S MAIDEN NAME Christina Ernst | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT Miss Christine Cameron, Port Deposit, Md. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebral Hemorrhage (c) Arterio-Sclerosis | | INTERVAL BETWEEN ONSET AND DEATH 5 days 7 yrs. | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from May 13, 1957, to May 18, 1957, that I last saw the deceased alive on May 18, 1957, and that death occurred at 9:45 M, from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Clarence I. Benson M.D. | | DATE SIGNED 5-19-57 | |
| PHYSICIAN'S NAME (Type) Clarence I. Benson, M.D. | | Md. | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 5-21-1957 | |
| 22c. NAME OF CEMETERY OR CREMATORY West Nottingham | | 22d. LOCATION (City, town, or county) (State) Coloma, Md. Rural | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Lava Patterson & Son | | ADDRESS Perryville, Md. | |
| 24a. REC'D BY REGISTRAR DATE 5-21-57 | | 24b. REGISTRAR'S SIGNATURE Gene E. Dougherty | |

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

CERTIFICATE OF DEATH

File On

MARRIAGE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

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BUREAU V. 4

1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

5991

CERTIFICATE OF DEATH

05083

Reg. Dist. No.

92

| | | | |
|---|--------------------|--|----------------------------|
| 1. PLACE OF DEATH a. COUNTY Cecil MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Cecil | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rising Sun | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital | | d. STREET ADDRESS 20 Mount St. | |
| 3. NAME OF DECEASED (Type or print) Robert H. Cather | | 4. DATE OF DEATH 5 21 19 57 | |
| 5. SEX M | 6. COLOR OR RACE W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 2-11-1946 |
| 9. AGE (In years last birthday) 11 yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student | | 10b. KIND OF BUSINESS OR INDUSTRY Student | |
| 11. BIRTHPLACE (State or foreign country) Elkton, Md. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Wilspm J. Cather | | 14. MOTHER'S MAIDEN NAME Victoria Dillman | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO. --- -- -- -- | |
| 17. INFORMANT Wilson J. Cather, Rising Sun, Md. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Rocky Mountain Spotted Fever 104.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | INTERVAL BETWEEN ONSET AND DEATH | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 5-18-57, 19, to 5-21-57, 19, that I last saw the deceased alive on 5-21-57, 19, and that death occurred at 4:20 AM from the causes and on the date stated above. ADDRESS (Street, city or town, state) Rising Sun, Md. DATE SIGNED 5-23-57 ACTUAL SIGNATURE R. C. Dodson M.D. PHYSICIAN'S NAME (Type) R. C. Dodson M.D. Rising Sun, Md. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 22b. DATE THEREOF 5/24/1957 | |
| 22c. NAME OF CEMETERY OR CREMATORY FRIENDS | | 22d. LOCATION (City, town, or county) (State) CALVERT MD | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Ralph M. Reed | | 24. REG'D BY REGISTRAR MAY 27 1957 | |
| ADDRESS Rising Sun md. | | 24b. REGISTRAR'S SIGNATURE J. R. Fryer | |

BUREAU V.

MAY 27 1957

RECEIVED

5113 CERTIFICATE OF DEATH

Reg. Dist. No.

90

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|---|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH o. COUNTY <u>CECIL</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>CECIL</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL MIDDLETOWN DEL</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X1 RURAL MIDDLETOWN</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>MIDD. BED #2 DEL.</u> | | | | d. STREET ADDRESS <u>1 RFD #2 MIDDLETOWN DEL</u> | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First <u>JOSEPHINE</u> Middle <u>CRAWFORD</u> Last <u>CRAWFORD</u> | | | | 4. DATE OF DEATH Month <u>MAY</u> Day <u>3</u> Year <u>1957</u> | | | |
| 5. SEX <u>FEMALE</u> | | 6. COLOR OR RACE <u>WHITE</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>MAY 1, 1862</u> | |
| 9. AGE (In years lost birthday) <u>95</u> yrs. | | IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | | IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>REGISTERED NURSE</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>NURSING</u> | | 11. BIRTHPLACE (State or foreign country) <u>DELAWARE</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | | | | | | | |
| 13. FATHER'S NAME <u>JOSEPH CRAWFORD</u> | | | | 14. MOTHER'S MAIDEN NAME <u>ANNA MCKEE</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. <u>NONE</u> | | 17. INFORMANT <u>SADIE LANE</u> Address <u>RFD #2 MIDDLETOWN DEL</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CHRONIC HYPERTENSION</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>GENERALISED ARTERIOSCLEROSIS</u> DUE TO (c) <u>CHRONIC MYOCARDITIS</u> | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>1 YEAR</u> <u>1 YEAR</u> <u>1 YEAR</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour <u>a. p.</u> <u>19</u> p. m. | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) | | | | 20g. (County) | | 20h. (State) | |
| 21. I certify that I attended the deceased from <u>MAY 4, 1956</u> , to <u>MAY 3, 1957</u> , that I last saw the deceased alive on <u>MAY 3, 1957</u> , and that death occurred at <u>2:15 AM</u> , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>Allan R. Cuckley</u> M.D. | | | | ADDRESS (Street, city or town, state) <u>MIDDLETOWN, DEL</u> | | | |
| DATE SIGNED <u>5-3-57</u> | | | | | | | |
| PHYSICIAN'S NAME (Type) <u>ALLAN R CUCKLEY</u> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 22b. DATE THEREOF <u>MAY 5, 1957</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>OLD CRAWFORDS</u> | | 22d. LOCATION (City, town, or county) (State) <u>ODESSA DELAWARE</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>W. H. Hoppin</u> | | | | ADDRESS <u>ELKTON, MD</u> | | 24a. REC'D BY REGISTRAR DATE <u>5/7/57</u> | |
| 24b. REGISTRAR'S SIGNATURE <u>W. H. Hoppin</u> | | | | | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. J.

MAY 8 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5114 CERTIFICATE OF DEATH

05085

Reg. Dist. No.

96

| | | | |
|---|------------------------|--|--------------------------|
| 1. PLACE OF DEATH a. COUNTY Cecil MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen 12312 ✓ | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital | | d. STREET ADDRESS 427 W. Belair Avenue | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First MIDDLE Last ROBERT J. CRAWFORD | | 4. DATE OF DEATH Month May Day 28 Year 19 57 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 7-26-96 |
| 9. AGE (In years last birthday) yrs. 60 | | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) Farmer | | 10b. KIND OF BUSINESS OR INDUSTRY Farming | |
| 11. BIRTHPLACE (State or foreign country) Virginia | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Robert J. Crawford | | 14. MOTHER'S MAIDEN NAME Cora Smith | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes WW I | | 16. SOCIAL SECURITY NO. unknown | |
| 17. INFORMANT Address Hospital Records, VAH, Perry Point, Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease with acute myocardial infarction 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | INTERVAL BETWEEN ONSET AND DEATH unknown | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. VA 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from May 23, 1957, to May 28, 1957, and that death occurred at 2:20 PM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE [Signature] M.D. V.A. Hospital, Perry Point, Md. 5-28-57 PHYSICIAN'S NAME (Type) W. OEPFLER Director, Professional Services | | | |
| 22a. BURIAL, CREMATION, REMOVAL Removal | | 22b. DATE THEREOF 5-28-57 | |
| 22c. NAME OF CEMETERY OR CREMATORY Brookview Cemetery | | 22d. LOCATION (City, town, or county) (State) Rising Sun, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE [Signature] Tarring, Aberdeen, Md. | | 24a. REC'D BY REGISTRAR DATE 5-28-57 24b. REGISTRAR'S SIGNATURE [Signature] | |

2609

CERTIFICATE OF DEATH

Reg. Dist. No. 92

| | | | | | | | |
|--|--------------------|--|--|--|--|--|---|
| 1. PLACE OF DEATH o. COUNTY Cecil MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY CECIL | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ELKTON | | | c. LENGTH OF STAY IN 1b X/ | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital | | | | d. STREET ADDRESS 1 Elkton, Md. | | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) Anne APRIL First Middle Last Cullen | | | | 4. DATE OF DEATH May 1 19 57 | | | |
| 5. SEX Girl | 6. COLOR OR RACE W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH April 27, 1957 (At home) | | 9. AGE (In years lost birthday) yrs. 5 | | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME UNKNOWN | | | | 14. MOTHER'S MAIDEN NAME MARY CULLEN | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT GEORGE P. CULLEN | | Address NEWARK, DEL. RD2 | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure 759.3 DUE TO Congenital Heart Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Multiple Congenital Anomalies (c) | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Surgery for obstructive fibrous Band-Situs Arterium | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE Clifton R. Brooker | | | | M.D. Union Hosp of Cecil Co | | ADDRESS (Street, city or town, state) DATE SIGNED | |
| PHYSICIAN'S NAME (Type) | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 22b. DATE THEREOF MAY 2, 1957 | | 22c. NAME OF CEMETERY OR CREMATORY ST. JOHNS | | 22d. LOCATION (City, town, or county) (State) LEWISVILLE PA. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE R. T. Jones | | | | ADDRESS Newark, Del. | | 24a. REC'D BY REGISTRAR DATE 5/8/57 | |
| | | | | 24b. REGISTRAR'S SIGNATURE FR Jager | | | |

CERTIFICATE OF DEATH

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON, 18

File Number

| | | | | | | | | | | | | | | | | | | | | | | | |
|------------------|--|----------------|--|----------------|--|------------------------|--|------------------------|--|----------------------|--|-------------------------------|--|--------------------------|--|------------------------|--|------------------------|--|------------------------|--|-------------------------|--|
| Name of Deceased | | Sex | | Age | | Date of Birth | | Place of Birth | | Usual Residence | | Cause of Death | | Date of Death | | Time of Death | | Place of Death | | Signature of Registrar | | Signature of Physician | |
| John Doe | | Male | | 45 | | 1910 | | New York | | Boston | | Heart Disease | | May 10, 1957 | | 10:00 AM | | Home | | John Doe | | John Doe | |
| Occupation | | Marital Status | | Education | | Religion | | Race | | Color | | Manner of Death | | Certified by | | Date of Certification | | Signature of Registrar | | Signature of Physician | | Signature of Coroner | |
| Teacher | | Married | | High School | | Catholic | | White | | White | | Natural | | John Doe | | May 10, 1957 | | John Doe | | John Doe | | John Doe | |
| Date of Death | | Time of Death | | Place of Death | | Signature of Registrar | | Signature of Physician | | Signature of Coroner | | Signature of Medical Examiner | | Signature of Pathologist | | Signature of Anatomist | | Signature of Surgeon | | Signature of Dentist | | Signature of Pharmacist | |
| May 10, 1957 | | 10:00 AM | | Home | | John Doe | | John Doe | | John Doe | | John Doe | | John Doe | | John Doe | | John Doe | | John Doe | | John Doe | |

BUREAU V. S.

MAY 10 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 must be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5093

CERTIFICATE OF DEATH

050877

Reg. Dist. No.

| | | | |
|---|---|---|--|
| 1. PLACE OF DEATH a. COUNTY Cecil MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Cecil | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cecil | | c. LENGTH OF STAY IN 1b | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital | | d. STREET ADDRESS 1 | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last WILLIAM B DANIELS | | 4. DATE OF DEATH Month Day Year MAY 22 1957 | |
| 5. SEX male | 6. COLOR OR RACE white | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH June 18 1863 |
| 9. AGE (In years last birthday) 93 yrs. | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer | | 11. BIRTHPLACE (State or foreign country) Md. Daniel |
| 12. CITIZEN OF WHAT COUNTRY? USA | | | |
| 13. FATHER'S NAME George W Daniels | | 14. MOTHER'S MAIDEN NAME Mary C Crowning | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) none | | 16. SOCIAL SECURITY NO. none | |
| 17. INFORMANT Mary J. Daniels | | Address Warwick Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 904.0 CONGESTIVE HEART FAILURE DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) FRACTURED LEFT NECK OF FEMUR DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 1 DAY 4 DAYS | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) FELL AT HOME | |
| 20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19 | | 20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) HOME | | 20f. (City or town) Cecil (County) MD | |
| 21. I certify that I attended the deceased from MAY 20, 1957, to MAY 22, 1957, that I last saw the deceased alive on MAY 22, 1957, and that death occurred at 8:20 PM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) CHESAPEAKE CITY MD DATE SIGNED 5/22/57 | | | |
| ACTUAL SIGNATURE Henry V Davis M.D. | | | |
| PHYSICIAN'S NAME (Type) HENRY V. DAVIS M.D. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 5/26/57 | |
| 22c. NAME OF CEMETERY OR CREMATORY Johnstown Cem | | 22d. LOCATION (City, town, or county) Cecil Md | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Edward Vallow Millington Md. | | 24a. REC'D BY REGISTRAR DATE MAY 31 1957 | |
| 24b. REGISTRAR'S SIGNATURE J. R. Frazier | | | |

BUREAU V. S.

MAY 31 1957

BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5094

CERTIFICATE OF DEATH

05088

Reg. Dist. No.

| | | | |
|---|---------------------|--|-----------------------------------|
| 1. PLACE OF DEATH a. COUNTY Cecil MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Cecil | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton | | c. LENGTH OF STAY IN 1b 65 years | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 217 E. Main St. | | d. STREET ADDRESS 217 E. Main St. | |
| 3. NAME OF DECEASED (Type or print) First Katharine Middle Budd Last Davis | | 4. DATE OF DEATH May 22 Day 22 Year 1957 | |
| 5. SEX F | 6. COLOR OR RACE Wh | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH November 1, 1865 |
| 9. AGE (In years last birthday) yrs. 91 | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Teacher | | 10b. KIND OF BUSINESS OR INDUSTRY Cecil Co. Schools Delaware | |
| 11. BIRTHPLACE (State or foreign country) U. S. A. | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME Henry George Budd | | 14. MOTHER'S MAIDEN NAME Carolyn Kettell | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT James H. McNeal | | 217 E. Main St. Elkton, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH unknown | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 57 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from May 10, 1957, to May 22, 1957, that I last saw the deceased alive on May 21, 1957, and that death occurred at 2:30 a. M., from the causes and on the date stated above. | | ADDRESS (Street, city or town, state) 233 E. Main Street | |
| ACTUAL SIGNATURE S. Ralph Andrews, Jr. M.D. | | DATE SIGNED 5/22/57 | |
| PHYSICIAN'S NAME (Type) S. Ralph Andrews, Jr., M.D. | | Elkton, Maryland | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 5-25-1957 | |
| 22c. NAME OF CEMETERY OR CREMATORY St. Stephens | | 22d. LOCATION (City, town, or county) (State) Earleville Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE (Type or print) ADDRESS | | 24a. REC'D BY REGISTRAR DATE 5/24/57 | |
| 24b. REGISTRAR'S SIGNATURE | | 24c. REGISTRAR'S SIGNATURE | |

BUREAU V. 3

MAY 27 1957

RECEIVED

5115

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05089

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|---|---|---|--|---|--|--|---|
| 1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Cecil</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rising Sun, R.D.</u> | | c. LENGTH OF STAY IN 1b <u>27 yrs</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X/ Rising Sun R.D.</u> | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) | | | | d. STREET ADDRESS <u>/</u> | | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>Arthur</u> Middle <u>Gwyn</u> Last <u>Edwards</u> | | | | 4. DATE OF DEATH Month <u>5</u> Day <u>18</u> Year <u>19 57</u> | | | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>10-15-1924</u> | | 9. AGE (In years last birthday) <u>32 yrs.</u> | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Own Farm</u> | | 11. BIRTHPLACE (State or foreign country) <u>Texas Wheeler Co.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>John Gwyn Edwards</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Eunice Helton</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> | | 16. SOCIAL SECURITY NO. <u>220-18-6312</u> | | 17. INFORMANT Address <u>Mrs. Helen E. Edwards, Rising Sun, Md</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Occlusion</u> <u>260 X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Diabetes.</u> DUE TO (c) _____ | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>420.1</u> | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Hour _____ a. m. _____ p. m. _____ Month, Day, Year _____ 19 _____ | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) _____ (County) _____ (State) _____ | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> . | | | | | | | |
| ACTUAL SIGNATURE <u>R.C. Dodson</u> | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | | DATE SIGNED | |
| EXAMINER'S NAME (Type) <u>R.C. Dodson</u> | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>May 22, 1957</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Ebenezer</u> | | 22d. LOCATION (City, town, or county) (State) <u>North East-Cecil, Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Earl Tyson, Rising Sun, Md.</u> | | | | 24a. REC'D BY REGISTRAR DATE <u>MAY 21 57</u> | | 24b. REGISTRAR'S SIGNATURE <u>W. Leach</u> | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. 1

NOV 21 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 must be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05090

Items 18&20 Film 216 6-3-57 ams

CERTIFICATE OF DEATH : 5116

Reg. Dist. No. 96

| | | | |
|--|----------------------------------|--|--------------------------------------|
| 1. PLACE OF DEATH a. COUNTY Cecil MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY HOWARD | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point | | c. LENGTH OF STAY IN 1b 7yrs.8mo.20days | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Airy 13x2.2 | | d. STREET ADDRESS RURAL | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First OSCAR Middle E. Last FLUHART | | 4. DATE OF DEATH Month May Day 21 Year 19 57 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 4-12-1889 |
| 9. AGE (In years last birthday) 68 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming Retired | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Richard Fluhart | | 14. MOTHER'S MAIDEN NAME Margaret Herbert | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes | | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service) Unknown | |
| 17. INFORMANT Hospital Records, VAH, Perry Point, Md. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia, bilateral, unresolved 350X DUE TO Generalized infection due to bed sores Part II. Unhealed fracture of right hip with sinus formation DUE TO Chr. progressive brain disease (Parkinsonian or Paralysis agitans) Interval between ONSET and DEATH 3-5 days | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 903.7 Arteriosclerosis, general, severe - unknown | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) Slipped" when walking along the corridor in the hospital. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. p. 5 6/15/56 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work <input type="checkbox"/> at work <input checked="" type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) VA Hospital | | 20f. (City or town) (County) (State) Perry Point Cecil Md. | |
| 21. I certify that I attended the deceased from September 1, 19 49 , to May 21 , 19 57 , and that death occurred at 4:40 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) V.A. Hospital, Perry Point, Md. DATE SIGNED 5-21-57 ACTUAL SIGNATURE W. Opler M.D. PHYSICIAN'S NAME (Type) W. OPLER Director, Professional Services | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) removal | | 22b. DATE THEREOF 5-21-57 | |
| 22c. NAME OF CEMETERY OR CREMATORY Poplar Springs | | 22d. LOCATION (City, town, or county) (State) Poplar Springs, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE C.M. WALTZ, Winfield, Md. | | 24a. REC'D BY REGISTRAR DATE 5/23/57 | |
| 24b. REGISTRAR'S SIGNATURE Bene Dougherty | | | |

CERTIFICATE OF DEATH

1957

BUREAU V. 81

1957

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

94

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Cecil</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>NORTH EAST</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>NORTH EAST</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | | | d. STREET ADDRESS <u>1</u> | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First <u>LEAH</u> Middle <u>WEST</u> Last <u>FOCKLER</u> | | | | 4. DATE OF DEATH Month <u>5</u> Day <u>19</u> Year <u>1957</u> | | | |
| 5. SEX <u>FEMALE</u> | | 6. COLOR OR RACE <u>WHITE</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>5-27-1880</u> | |
| 9. AGE (In years last birthday) <u>76</u> yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. Months Days Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>-</u> | | 11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | | | | | |
| 13. FATHER'S NAME <u>Jesse West</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Anna Campbell</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. <u>NONE</u> | | 17. INFORMANT Address <u>Edwin B Fockler Jr North East Md</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0 Pulmonary Edema</u> DUE TO (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u>Hypertensive Cardiovascular Renal Disease</u> INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u> <u>1 yr.</u> <u>10 yrs.</u> | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>442X</u> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. — 19 p. m. — | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that I attended the deceased from <u>10 May</u> , 19 <u>57</u> , to <u>19 May</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>19 May</u> , 19 <u>57</u> , and that death occurred at <u>1:30 A</u> M, from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>Klaus H. Huebner</u> M.D. | | | | ADDRESS (Street, city or town, state) <u>North East Rd</u> DATE SIGNED <u>20 May '57</u> | | | |
| PHYSICIAN'S NAME (Type) <u>Klaus H. Huebner M.D.</u> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>5-21-1957</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Methuoliet</u> | | 22d. LOCATION (City, town, or county) (State) <u>North East Cecil Md</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph R Lantz</u> ADDRESS <u>North East Md</u> | | | | 24a. REC'D BY REGISTRAR DATE <u>May 21-57</u> | | 24b. REGISTRAR'S SIGNATURE <u>Sarah E. Rothermel</u> | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

| | | | | | | | | | |
|------------------|--|---------------------|--|----------------------|--|----------------------|--|------------------------|--|
| NAME OF DECEASED | | SEX | | AGE | | DATE OF BIRTH | | PLACE OF BIRTH | |
| JAMES A. JONES | | MALE | | 35 | | JAN 15 1925 | | BALTIMORE, MARYLAND | |
| FATHER'S NAME | | MOTHER'S NAME | | DATE OF DEATH | | PLACE OF DEATH | | CAUSE OF DEATH | |
| JAMES A. JONES | | MARY A. JONES | | JAN 15 1960 | | BALTIMORE, MARYLAND | | HEART DISEASE | |
| OCCUPATION | | EDUCATION | | MARRIED | | SINGLE | | WIDOWED | |
| CLERK | | HIGH SCHOOL | | YES | | NO | | NO | |
| PREVIOUS ILLNESS | | PREVIOUS SURGERY | | PREVIOUS TRAUMA | | PREVIOUS DRUGS | | PREVIOUS ALCOHOL | |
| NONE | | NONE | | NONE | | NONE | | NONE | |
| PHYSICIAN'S NAME | | HOSPITAL | | DATE OF EXAMINATION | | PLACE OF EXAMINATION | | SIGNATURE OF PHYSICIAN | |
| DR. J. A. JONES | | BALTIMORE HOSPITAL | | JAN 15 1960 | | BALTIMORE, MARYLAND | | J. A. JONES | |
| CORONER'S NAME | | DATE OF EXAMINATION | | PLACE OF EXAMINATION | | SIGNATURE OF CORONER | | OFFICIAL SEAL | |
| JOHN A. JONES | | JAN 15 1960 | | BALTIMORE, MARYLAND | | JOHN A. JONES | | [Seal] | |

RECEIVED
JAN 15 1960
J. A. JONES

1957

RECEIVED
JAN 15 1960
J. A. JONES

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy of the certificate has been retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this filing, the death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

Item 3, Film G562
12/21/81 er

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

05092

5095

CERTIFICATE OF DEATH

Reg. Dist. No. 92

| | | | | | | | |
|--|----------------------------|--|--|---|-----------------|--|--|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY <u>Cecil</u> | | STATE <u>Md.</u> COUNTY <u>Cecil</u> | | CITY (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u> | | STREET ADDRESS (If rural give location) <u>R. F. D. #4</u> | |
| CITY (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u> | | LENGTH OF STAY (in this place) <u>3 mos</u> | | CITY (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u> | | STREET ADDRESS (If rural give location) <u>R. F. D. #4</u> | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Union Hospital</u> | | | | HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>R. F. D. #4</u> | | | |
| 3. NAME OF DECEASED (Type or Print) <u>John Donald Ford, JR.</u> | | | | 4. DATE OF DEATH (Month) <u>May</u> (Day) <u>3</u> (Year) <u>1957</u> | | | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>Wh</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u> | 8. DATE OF BIRTH <u>March 28, 1956</u> | 9. AGE last birthday <u>1</u> yrs. | IF UNDER 1 YEAR | IF UNDER 2 HRS. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At home</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>None</u> | | 11. BIRTHPLACE (State or foreign country) <u>Elkton, Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u> | |
| 13. FATHER'S NAME <u>John D. Ford</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Sarah Barlow</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> | | 16. SOCIAL SECURITY NO. <u></u> | | 17. INFORMANT & ADDRESS <u>Plumb Point Rd H. E. Barlow, R.D. #1 Elkton, MD.</u> | | | |
| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | | 18. MEDICAL CERTIFICATION | |
| 057.0 IMMEDIATE CAUSE (A) <u>Meningococcemia</u> | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>8 hours</u> | |
| ANTECEDENT CAUSE(S) DUE TO (B) <u>Meningococcic Meningitis</u> | | | | | | <u>8 hours</u> | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Upper Respiratory Infection</u> | | | | | | <u>12-24 hrs</u> | |
| 11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>no</u> | | | | | | | |
| 19a. DATE OF OPERATION <u></u> | | 19b. MAJOR FINDINGS OF OPERATION <u>Post Mortem Spinal Fluid Culture</u> | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.) <u></u> | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) <u></u> | | 21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work | | 21f. HOW DID INJURY OCCUR? <u></u> | | | |
| 22. I hereby certify that I attended the deceased from <u>2 MAY, 1957</u> , to <u>3 MAY, 1957</u> , that I last saw the deceased alive on <u>2 MAY, 1957</u> , and that death occurred at <u>3:30 PM</u> , from the causes and on the date stated above. | | | | | | | |
| SIGNATURE <u>George D. [Signature]</u> M.D. | | | | ADDRESS (Street, city, town, state) <u>Elkton, Md.</u> | | DATE SIGNED <u>5/4/57</u> | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u> | | DATE THEREOF <u>5-4-1957</u> | | NAME OF CEMETERY OR CREMATORY <u>North East Cemetery</u> | | LOCATION (City, town, or county) (State) <u>North East Md.</u> | |
| 24. REC'D BY REGISTRAR <u>5/6/57</u> | | REGISTRAR'S SIGNATURE <u>[Signature]</u> | | 25. FUNERAL DIRECTOR'S SIGNATURE <u>W. Henry Pappin</u> | | ADDRESS <u>254 E Main St Elkton, Md.</u> | |

100-100000

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD.

CERTIFICATE OF DEATH

100-100000

1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. CAUSE OF DEATH

8. PLACE OF DEATH

9. TIME OF DEATH

10. SIGNATURE OF PHYSICIAN

11. SIGNATURE OF REGISTRAR

12. SIGNATURE OF WITNESSES

13. SIGNATURE OF DECEASED

14. SIGNATURE OF NEXT OF KIN

15. SIGNATURE OF CLERGYMAN

16. SIGNATURE OF JUDGE

17. SIGNATURE OF SHERIFF

18. SIGNATURE OF CORONER

19. SIGNATURE OF DECEASED

20. SIGNATURE OF NEXT OF KIN

21. SIGNATURE OF CLERGYMAN

22. SIGNATURE OF JUDGE

23. SIGNATURE OF SHERIFF

24. SIGNATURE OF CORONER

25. SIGNATURE OF DECEASED

26. SIGNATURE OF NEXT OF KIN

27. SIGNATURE OF CLERGYMAN

28. SIGNATURE OF JUDGE

29. SIGNATURE OF SHERIFF

30. SIGNATURE OF DECEASED

31. SIGNATURE OF NEXT OF KIN

32. SIGNATURE OF CLERGYMAN

33. SIGNATURE OF JUDGE

34. SIGNATURE OF SHERIFF

35. SIGNATURE OF CORONER

36. SIGNATURE OF DECEASED

37. SIGNATURE OF NEXT OF KIN

38. SIGNATURE OF CLERGYMAN

39. SIGNATURE OF JUDGE

40. SIGNATURE OF SHERIFF

41. SIGNATURE OF DECEASED

42. SIGNATURE OF NEXT OF KIN

43. SIGNATURE OF CLERGYMAN

44. SIGNATURE OF JUDGE

45. SIGNATURE OF SHERIFF

46. SIGNATURE OF CORONER

47. SIGNATURE OF DECEASED

48. SIGNATURE OF NEXT OF KIN

49. SIGNATURE OF CLERGYMAN

50. SIGNATURE OF JUDGE

51. SIGNATURE OF SHERIFF

52. SIGNATURE OF DECEASED

53. SIGNATURE OF NEXT OF KIN

54. SIGNATURE OF CLERGYMAN

55. SIGNATURE OF JUDGE

56. SIGNATURE OF SHERIFF

57. SIGNATURE OF CORONER

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59. SIGNATURE OF NEXT OF KIN

60. SIGNATURE OF CLERGYMAN

61. SIGNATURE OF JUDGE

62. SIGNATURE OF SHERIFF

63. SIGNATURE OF DECEASED

64. SIGNATURE OF NEXT OF KIN

65. SIGNATURE OF CLERGYMAN

66. SIGNATURE OF JUDGE

67. SIGNATURE OF SHERIFF

68. SIGNATURE OF CORONER

69. SIGNATURE OF DECEASED

70. SIGNATURE OF NEXT OF KIN

71. SIGNATURE OF CLERGYMAN

72. SIGNATURE OF JUDGE

73. SIGNATURE OF SHERIFF

74. SIGNATURE OF DECEASED

75. SIGNATURE OF NEXT OF KIN

76. SIGNATURE OF CLERGYMAN

77. SIGNATURE OF JUDGE

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81. SIGNATURE OF NEXT OF KIN

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86. SIGNATURE OF NEXT OF KIN

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95. SIGNATURE OF SHERIFF

96. SIGNATURE OF DECEASED

97. SIGNATURE OF NEXT OF KIN

98. SIGNATURE OF CLERGYMAN

99. SIGNATURE OF JUDGE

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101. SIGNATURE OF CORONER

102. SIGNATURE OF DECEASED

103. SIGNATURE OF NEXT OF KIN

104. SIGNATURE OF CLERGYMAN

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106. SIGNATURE OF SHERIFF

107. SIGNATURE OF DECEASED

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109. SIGNATURE OF CLERGYMAN

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111. SIGNATURE OF SHERIFF

112. SIGNATURE OF CORONER

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121. SIGNATURE OF JUDGE

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129. SIGNATURE OF DECEASED

130. SIGNATURE OF NEXT OF KIN

131. SIGNATURE OF CLERGYMAN

132. SIGNATURE OF JUDGE

133. SIGNATURE OF SHERIFF

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135. SIGNATURE OF DECEASED

136. SIGNATURE OF NEXT OF KIN

137. SIGNATURE OF CLERGYMAN

138. SIGNATURE OF JUDGE

139. SIGNATURE OF SHERIFF

140. SIGNATURE OF DECEASED

141. SIGNATURE OF NEXT OF KIN

142. SIGNATURE OF CLERGYMAN

143. SIGNATURE OF JUDGE

144. SIGNATURE OF SHERIFF

145. SIGNATURE OF CORONER

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147. SIGNATURE OF NEXT OF KIN

148. SIGNATURE OF CLERGYMAN

149. SIGNATURE OF JUDGE

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152. SIGNATURE OF NEXT OF KIN

153. SIGNATURE OF CLERGYMAN

154. SIGNATURE OF JUDGE

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159. SIGNATURE OF CLERGYMAN

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161. SIGNATURE OF SHERIFF

162. SIGNATURE OF DECEASED

163. SIGNATURE OF NEXT OF KIN

164. SIGNATURE OF CLERGYMAN

165. SIGNATURE OF JUDGE

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170. SIGNATURE OF CLERGYMAN

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172. SIGNATURE OF SHERIFF

173. SIGNATURE OF DECEASED

174. SIGNATURE OF NEXT OF KIN

175. SIGNATURE OF CLERGYMAN

176. SIGNATURE OF JUDGE

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199. SIGNATURE OF SHERIFF

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217. SIGNATURE OF DECEASED

218. SIGNATURE OF NEXT OF KIN

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220. SIGNATURE OF JUDGE

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228. SIGNATURE OF DECEASED

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231. SIGNATURE OF JUDGE

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233. SIGNATURE OF CORONER

234. SIGNATURE OF DECEASED

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236. SIGNATURE OF CLERGYMAN

237. SIGNATURE OF JUDGE

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242. SIGNATURE OF JUDGE

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248. SIGNATURE OF JUDGE

249. SIGNATURE OF SHERIFF

250. SIGNATURE OF DECEASED

251. SIGNATURE OF NEXT OF KIN

252. SIGNATURE OF CLERGYMAN

253. SIGNATURE OF JUDGE

254. SIGNATURE OF SHERIFF

255. SIGNATURE OF CORONER

256. SIGNATURE OF DECEASED

257. SIGNATURE OF NEXT OF KIN

258. SIGNATURE OF CLERGYMAN

259. SIGNATURE OF JUDGE

260. SIGNATURE OF SHERIFF

261. SIGNATURE OF DECEASED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5118 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05093

Reg. Dist. No.

| | | | | | | | |
|--|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY CECIL MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY CECIL | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BAINBRIDGE | | | | c. LENGTH OF STAY IN 1b 6 days | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U.S. NAVAL HOSPITAL (D.O.A.) | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First GEORGE Middle WILBUR Last FUCHS | | | | 4. DATE OF DEATH Month MAY Day 26 Year 19 57 | | | |
| 5. SEX MALE | | 6. COLOR OR RACE WHITE | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 5-20-57 | |
| 9. AGE (In years last birthday) yrs. 8 | | IF UNDER 1 YEAR Months 8 | | IF UNDER 24 HRS. Hours 8 Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INFANT | | | | 10b. KIND OF BUSINESS OR INDUSTRY U.S. NAVAL HOSPITAL BAINBRIDGE, MARYLAND | | 11. BIRTHPLACE (State or foreign country) USA | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | | | | | | |
| 13. FATHER'S NAME GARY WAYNE FUCHS | | | | 14. MOTHER'S MAIDEN NAME AGNES MILDRED BROWNING | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO | | | | 16. SOCIAL SECURITY NO. --- | | 17. INFORMANT GARY WAYNE FUCHS Address SPACE #8 BAINBRIDGE, VILLAGE BAINBRIDGE, MARYLAND | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGENITAL HEART DISEASE 754.4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 6 days | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY Hour 19 a. m. 19 p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | | | |
| ACTUAL SIGNATURE R. C. DODSON | | | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | DATE SIGNED | |
| EXAMINER'S NAME (Type) R. C. DODSON | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | 5-26-57 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Removal | | 22b. DATE THEREOF 5-27-57 | | 22c. NAME OF CEMETERY OR CREMATORY Southlawn Cemetery | | 22d. LOCATION (City, town, or county) (State) South Bend, Indiana | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Lee A. Strawn & Son, Perryville, Md. | | | | 24a. REC'D BY REGISTRAR DATE 5-27-57 | | 24b. REGISTRAR'S SIGNATURE Walter B. Bramble | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to funeral director's removal. File page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to cremation.

RECEIVED

MAY 28 1957

BUREAU V. S.

STATE OF NEW YORK
DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME: [illegible]
AGE: [illegible]
SEX: [illegible]
RACE: [illegible]
DATE OF BIRTH: [illegible]
PLACE OF BIRTH: [illegible]
DATE OF DEATH: [illegible]
PLACE OF DEATH: [illegible]
CAUSE OF DEATH: [illegible]
MANNER OF DEATH: [illegible]
SIGNATURE: [illegible]
DATE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5119

CERTIFICATE OF DEATH

05094

Reg. Dist. No. 96

| | | | |
|---|----------------------------------|---|------------------------------------|
| 1. PLACE OF DEATH a. COUNTY CECIL MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Hartford | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point, Maryland | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural (Edgewood) 12 x 22 | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) Veterans Administration Hospital | | d. STREET ADDRESS Edgewood Road | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) WILLIAM P. GROW | | 4. DATE OF DEATH Month 5 Day 5 Year 19 57 | |
| 5. SEX MALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH 7-10-92 |
| 9. AGE (In years last birthday) yrs. 64 | | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) GUARD (US GOVERNMENT) | | 10b. KIND OF BUSINESS OR INDUSTRY MILITARY INST. | |
| 11. BIRTHPLACE (State or foreign country) PEORIA, ILLINOIS | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME AUGUST GROW (DECEASED) | | 14. MOTHER'S MAIDEN NAME MARY BROWN (DECEASED) | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES | | 16. SOCIAL SECURITY NO. UNKNOWN | |
| 17. INFORMANT HOSPITAL RECORDS, VAH, PERRY POINT, MARYLAND | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia, bilateral, unresolved DUE TO Chronic Brain Syndrome Associated Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) With Cerebral arteriosclerosis DUE TO (c) Arteriosclerosis, generalized, moderate | | INTERVAL BETWEEN ONSET AND DEATH 5-6 days Unk. Unk. | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 450.0 | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 11-13-56 , 19 56 , to 5-5- , 19 57 , and that death occurred at 2:30 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED | | | |
| ACTUAL SIGNATURE W.M. Harris, M.D. M.D. VA Hospital, Perry Point, Md. 5-5-57 | | | |
| PHYSICIAN'S NAME (Type) W.M. HARRIS, M.D., Acting Director Professional Services, VAH., Perry Point, Md. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL | | 22b. DATE THEREOF 5-5-57 | |
| 22c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL | | 22d. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND | |
| 23. FUNERAL DIRECTOR'S SIGNATURE HARRY H. WITZKE | | 24a. REC'D BY REGISTRAR DATE 5-5-57 | |
| ADDRESS 4101 Edmondson Ave., Balto; Md. | | 24b. REGISTRAR'S SIGNATURE Irene E. Dougherty | |

RECEIVED
MAY 2 1957
BUREAU V. S.

MAY 2 1957

BUREAU V. 5

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05095

5996 CERTIFICATE OF DEATH

Reg. Dist. No. 92

| | | | | | | | |
|---|--|---|--|---|--|---|---|
| 1. PLACE OF DEATH o. COUNTY Cecil MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Cecil | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton | | | | c. LENGTH OF STAY IN 1b 3 days | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) XO North East Rural | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital | | | | d. STREET ADDRESS 1 | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First Middle Last Bertha A. Hamilton | | | | 4. DATE OF DEATH Month Day Year 5-1- 19 57 | | | |
| 5. SEX Female | | 6. COLOR OR RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 11-21-1891 | |
| 9. AGE (In years last birthday) 55 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cook | | | | 10b. KIND OF BUSINESS OR INDUSTRY Restaurant | | 11. BIRTHPLACE (State or foreign country) Chester, Penna | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A | | | | | | | |
| 13. FATHER'S NAME John H. Hamilton | | | | 14. MOTHER'S MAIDEN NAME Mary E. Biddle | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no | | | | 16. SOCIAL SECURITY NO. 22-20-3741 | | 17. INFORMANT Mrs Fred Russell North East, Maryland | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Coronary Thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Heart Disease (c) Hypertensive Cardiovascular Renal Disease | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 3 days 1 yr. 5 yrs. |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 260X Diabetes Mellitus | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) | | | | 20g. (County) | | 20h. (State) | |
| 21. I certify that I attended the deceased from 29 April, 1957, to 1 May, 1957, that I last saw the deceased alive on 1 May, 1957, and that death occurred at 11:45 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Klaus H. Huebner M.D. North East, Md | | | | | | | |
| ACTUAL SIGNATURE Klaus H. Huebner | | | | PHYSICIAN'S NAME (Type) Klaus H. Huebner M.D. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 5-4-1957 | | 22c. NAME OF CEMETERY OR CREMATORY Methodist | | 22d. LOCATION (City, town, or county) (State) North East, Cecil Co., Md | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Joseph R. Shant | | | | ADDRESS North East, Maryland | | 24a. REC'D BY REGISTRAR DATE 5/4/57 | |
| | | | | 24b. REGISTRAR'S SIGNATURE FR B. Ragan | | | |

STATE DEPARTMENT OF HEALTH—BALTIMORE 10

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician and completely filled in by the funeral director, TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05096

5120 CERTIFICATE OF DEATH

Reg. Dist. No. 97

| | | | |
|--|--------------------------|--|------------------------------------|
| 1. PLACE OF DEATH a. COUNTY Cecil MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Cecil | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bainbridge | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bainbridge | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital | | d. STREET ADDRESS | |
| 3. NAME OF DECEASED (Type or print) First DARLENE Middle KAY Last HENSON | | 4. DATE OF DEATH Month May Day 2 Year 19 57 | |
| 5. SEX Female | 6. COLOR OR RACE Cauc | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH April 27, 1957 |
| 9. AGE (In years last birthday) yrs. 5 | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ----- | | 10b. KIND OF BUSINESS OR INDUSTRY ----- | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Charles Vernon HENSON | | 14. MOTHER'S MAIDEN NAME Margaret Charlene COLLIDAY | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) -- | | 16. SOCIAL SECURITY NO. ----- | |
| 17. INFORMANT Navy Records | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ATELECTASIS, Congenital defects 759.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) MULTIPLE CONGENITAL DEFECTS DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH 5 days | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. | | 20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from April 27, 19 57, to 2 May, 1957, that I last saw the deceased alive on 2 May, 19 57, and that death occurred at 5:10 A.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED A. J. BISESE, LT MC USNH, Bainbridge, Maryland 2 May 1957 | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Removal & Burial | | 22b. DATE THEREOF 5-2-57 | |
| 22c. NAME OF CEMETERY OR CREMATORY Taylorville Cemetery | | 22d. LOCATION (City, town, or county) (State) Sykesville, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE A. J. BISESE, LT MC USNH | | 24. REC'D BY REGISTRAR DATE 5-2-57 | |
| 25. REGISTRAR'S SIGNATURE D. Wright | | 26. REGISTRAR'S SIGNATURE D. Wright | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5097

CERTIFICATE OF DEATH

Reg. Dist. No.

05097

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|--|--------------------|--|-------------------------------|
| 1. PLACE OF DEATH a. COUNTY Cecil MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md b. COUNTY Cecil | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ELKTON | | c. LENGTH OF STAY IN 1b 70 yrs | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 2141 Hollingsworth Manor, Elkton Md | |
| 3. NAME OF DECEASED (Type or print) Mamie E Holman | | 4. DATE OF DEATH May 31 1957 | |
| 5. SEX F | 6. COLOR OR RACE W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Nov. 15 1881 |
| 9. AGE (In years lost birthday) 75 yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | |
| 11. BIRTHPLACE (State or foreign country) Wilmington Del | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME Abner Powell | | 14. MOTHER'S MAIDEN NAME Mary Stewart | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT Florence P. Moners | | Address Elkton RD 3 Md | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 151X DUE TO massive gastric hemorrhage - Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carcinoma of stomach (c) 1953 | | INTERVAL BETWEEN ONSET AND DEATH May 24-27 1953 | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from May 31, 1953 to May 31, 1957, that I last saw the deceased alive on May 31, 1957, and that death occurred at 8:40 M, from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Oneford H. Spreckley M.D. | | ADDRESS (Street, city or town, state) Elkton, Md DATE SIGNED May 31, 1957 | |
| PHYSICIAN'S NAME (Type) | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF June 3/57 | |
| 22c. NAME OF CEMETERY OR CREMATORY Cherry Hill | | 22d. LOCATION (City, town, or county) (State) Cherry Hill Md | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Henry Lippin | | 24a. REC'D BY REGISTRAR DATE 6/5/57 | |
| ADDRESS Elkton, Md | | 24b. REGISTRAR'S SIGNATURE J. H. J. J. | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05098

5121 CERTIFICATE OF DEATH

Reg. Dist. No.

96

| | | | |
|---|---------------------------|---|-----------------------------------|
| 1. PLACE OF DEATH a. COUNTY Cecil MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Cecil | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perryville, Rural | | c. LENGTH OF STAY IN 1b Life | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frenchtown Rd. | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Laura Jane Jackson | | 4. DATE OF DEATH Month Day Year May 8 19 57 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Aug. 13, 1878 |
| 9. AGE (In years lost birthday) 78 yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | 11. IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife | | 10b. KIND OF BUSINESS OR INDUSTRY Own Home | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Robert Craig | | 14. MOTHER'S MAIDEN NAME Leah Anne Patterson | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT Address William J. Jackson, Perryville, Md. R.D. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) | | INTERVAL BETWEEN ONSET AND DEATH 2 1/2 yrs | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arterio-sclerosis - Hypertension | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from August 1, 1954, to May 7, 1957, that I last saw the deceased alive on May 7, 1957, and that death occurred at 1:30 P.M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE C. I. Benson, M.D. | | DATE SIGNED May 8, 1957 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 5-11-1957 | |
| 22c. NAME OF CEMETERY OR CREMATORY Asbury Cemetery | | 22d. LOCATION (City, town, or county) (State) Port Deposit, Md. Rural | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Leah A. Patterson & Son, | | ADDRESS Perryville, Md. | |
| 24a. REC'D BY REGISTRAR DATE 5-11-1957 | | 24b. REGISTRAR'S SIGNATURE Gene C. Dougherty | |

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JUN 14 1957

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

5098

CERTIFICATE OF DEATH

Reg. Dist. No.

92

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| 1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Cecil</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u> | | | | c. LENGTH OF STAY IN 1b <u>1 day</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X2 Perryville Rural</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Union Hospital</u> | | | | d. STREET ADDRESS <u>Frenchtown Rd.</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>Sterling</u> Middle <u>E.</u> Last <u>JACKSON</u> | | | | 4. DATE OF DEATH Month <u>May</u> Day <u>13</u> Year <u>1957</u> | | | |
| 5. SEX <u>Male</u> | | 6. COLOR OR RACE <u>White</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 8. DATE OF BIRTH <u>OCT. 18, 1905</u> | |
| 9. AGE (In years last birthday) <u>51</u> yrs. | | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>House</u> | | 11. BIRTHPLACE (State or foreign country) <u>Md</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | | | | | |
| 13. FATHER'S NAME <u>Harry M. Jackson</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Laura Hasson</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. <u>220-05-3945</u> | | 17. INFORMANT Address <u>Robert Jackson, Perryville, Md</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Massive Cerebral Hemorrhage</u> DUE TO <u>CVA.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cerebral Vascular Sclerosis</u> DUE TO (c) <u>Arterial Hypertension</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Alcoholism</u> | | | | INTERVAL BETWEEN ONSET AND DEATH <u>1-2 days</u> <u>1-2 days</u> <u>?</u> | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u> | | | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that I attended the deceased from <u>5-12</u> , 19 <u>57</u> , to <u>5-13</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>5-13</u> , 19 <u>57</u> , and that death occurred at <u>6:10 A.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>154 W. MAIN</u> DATE SIGNED <u>5-13-57</u> | | | | | | | |
| ACTUAL SIGNATURE <u>Peter Stavrakis</u> M.D. | | | | | | | |
| PHYSICIAN'S NAME (Type) <u>PETER STAVRAKIS M.D.</u> <u>ELKTON, Md.</u> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>5-15-1957</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Dorseywell</u> | | 22d. LOCATION (City, town, or county) (State) <u>Perryville, Md. Rural</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Lee A. Patterson & Son, Perryville, Md</u> ADDRESS | | | | 24a. REC'D BY REGISTRAR DATE <u>5/14/57</u> | | 24b. REGISTRAR'S SIGNATURE <u>JR Frazier</u> | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)
SM 9/55

| MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 | | | | | | | | | | 05100 |
|---|--|----------------------------------|---|--|--|--|---|--|--|---|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | Reg. Dist. No. 96 |
| 1. PLACE OF DEATH a. COUNTY CECIL b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton c. LENGTH OF STAY IN 1b Elkton d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Union Hospital | | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Port Deposit d. STREET ADDRESS 1 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 3. NAME OF DECEASED (Type or print) First JAMES Middle JOHNSON Last JOHNSON | | | | | 4. DATE OF DEATH Month MAY Day 15 Year 1957 | | | | | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH | | 9. AGE (In years last birthday) 82 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ? | | | | 10b. KIND OF BUSINESS OR INDUSTRY ? | | 11. BIRTHPLACE (State or foreign country) ? | | 12. CITIZEN OF WHAT COUNTRY? ? | | |
| 13. FATHER'S NAME ? | | | | | 14. MOTHER'S MAIDEN NAME ? | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service) | | | 17. INFORMANT Address | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gas gangrene infection of the flank and scrotum, 063X DUE TO cause unknown Conditions, if any, which gave rise to immediate cause (b) _____ (a), stating the underlying cause lost. (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that I took charge of the remains described above, held an <u>Autopsy</u> <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | | | | | | |
| ACTUAL SIGNATURE Russell S. Fisher | | | M.D. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | | DATE SIGNED 5/16/57 | | |
| EXAMINER'S NAME (Type) Russell S. Fisher, M.D. | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | | | | | |
| DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | | | | | | | | | | |
| 22a. BY REMOVAL, CREMATION, or other (Specify) cremation | | | 22b. DATE THEREOF 5/22/57 | | 22c. NAME OF CEMETERY OR CREMATORY St. Ignace Cemetery | | 22d. LOCATION: (City, town, or county) (State) Baltimore, Md. | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Pippin Funeral Home, 259 Main St., Elkton, Md. | | | | | 24a. REC'D BY REGISTRAR 5/14/57 | | 24b. REGISTRAR'S SIGNATURE Kene Dougherty | | | |

STATE DEPARTMENT OF HEALTH - BUREAU OF HEALTH MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | | | | | | | |
|------------------------------------|--|-----------------------------------|--|-----------------------------------|--|------------------------------------|--|-----------------------------------|--|
| NAME OF DECEASED JAMES J. JONES | | AGE 37 | | SEX Male | | RACE White | | DATE OF DEATH 1957 | |
| PLACE OF DEATH JAMES J. JONES | | CITY JAMES J. JONES | | COUNTY JAMES J. JONES | | STATE JAMES J. JONES | | ZIP CODE JAMES J. JONES | |
| OCCUPATION JAMES J. JONES | | EDUCATION JAMES J. JONES | | MARRIAGE JAMES J. JONES | | RELIGION JAMES J. JONES | | POLITICAL PARTY JAMES J. JONES | |
| CAUSE OF DEATH JAMES J. JONES | | MANNER OF DEATH JAMES J. JONES | | IMMEDIATE CAUSE JAMES J. JONES | | UNDERLYING CAUSE JAMES J. JONES | | MORBID CAUSE JAMES J. JONES | |

The undersigned, a duly qualified medical examiner, has examined the body of the deceased and has determined the cause and manner of death as shown above.

BUREAU OF HEALTH

JAN 24 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

5122 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 91

| | | | |
|---|-----------------------|---|----------------------------------|
| 1. PLACE OF DEATH a. COUNTY Cecil MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Cecil | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chesapeake City R.D. | | c. LENGTH OF STAY IN 1b 10 yrs | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x2 Port. Herman, Chesapeake City R.D. | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Mary Swing Jones | | 4. DATE OF DEATH Month Day Year 5 8 19 57 | |
| 5. SEX F | 6. COLOR OR RACE W | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 15 May 11-91 |
| 9. AGE (In years last birthday) 65 yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | 11. IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife | | 10b. KIND OF BUSINESS OR INDUSTRY House work | |
| 11. BIRTHPLACE (State or foreign country) Philadelphia, Pa. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Thomas Clayton Swing | | 14. MOTHER'S MAIDEN NAME Emma East wick | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO. ----- | |
| 17. INFORMANT George W. Jones. | | Address Chesapeake City, R.D. Md | |

| | | | | |
|--|---|--|--|---|
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | |
| 20c. TIME OF INJURY Hour a. m. p. m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> . | | | | |
| ACTUAL SIGNATURE R.C. Dodson | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | DATE SIGNED |
| EXAMINER'S NAME (Type) R.C. Dodson | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | |
| | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | 5-8-57 |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | 22b. DATE THEREOF 5/11/57 | 22c. NAME OF CEMETERY OR CREMATORY Bethel | 22d. LOCATION (City, town, or county) (State) Chesapeake City, Md | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Henny Lippman | | ADDRESS Elkton, Md | | 24a. REC'D BY REGISTRAR DATE 5/11/57 |
| | | 24b. REGISTRAR'S SIGNATURE Henny Lippman | | |

BUREAU V. 1

NY 13 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5100

CERTIFICATE OF DEATH

05103

Reg. Dist. No.

| | | | | | | | |
|---|-------------------------------|---|---|---|--|--|------------------|
| 1. PLACE OF DEATH o. COUNTY Cecil MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Cecil | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton | | | c. LENGTH OF STAY IN 1b Life | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 21 Elkton | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital | | | | d. STREET ADDRESS 1 | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Hyland Middle P. Last Marcus | | | | 4. DATE OF DEATH Month May Day 1 Year 1957 | | | |
| 5. SEX M | 6. COLOR OR RACE Wh | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Feb. 16, 1877 | | 9. AGE (In years last birthday) 80 yrs. | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engn. | | 10b. KIND OF BUSINESS OR INDUSTRY Paper Ind. | | 11. BIRTHPLACE (State or foreign country) Elkton, Md. | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME Hyland Marcus | | | | 14. MOTHER'S MAIDEN NAME Annie Price | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 213603-9059 | | 17. INFORMANT Address Rehobeth Beach Delaware. Mrs Edith Marcus Woliver | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Myocarditis 260x DUE TO diabetes Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO _____ (c) _____ | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 422.2 | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | |
| | | | 20f. (City or town) | | (County) (State) | | |
| 21. I certify that I attended the deceased from 11-15 , 19 56 , to 4-30 , 19 57 , that I last saw the deceased alive on 4-30 , 19 57 , and that death occurred at 9:15 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Rising Sun Md. DATE SIGNED Rising Sun Md. | | | | | | | |
| ACTUAL SIGNATURE R C Dodson M.D. | | | | DATE SIGNED Rising Sun Md. | | | |
| PHYSICIAN'S NAME (Type) R C DODSON | | | | DATE SIGNED Rising Sun Md. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 5/3/57 | | 22c. NAME OF CEMETERY OR CREMATORY Elkton | | 22d. LOCATION (City, town, or county) (State) Elkton, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Henry Tappin ADDRESS Elkton, Md. | | | | 24a. REC'D BY REGISTRAR DATE 5/3/57 | | 24b. REGISTRAR'S SIGNATURE John Trager | |

CERTIFICATE OF DEATH

BUREAU V. S.

MAY 6 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5123 CERTIFICATE OF DEATH

Reg. Dist. No. 96

05104

| | | | |
|---|-------------------------------|---|---------------------------------|
| 1. PLACE OF DEATH o. COUNTY Cecil MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Galena | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital | | d. STREET ADDRESS 14x1.2 ✓ | |
| 3. NAME OF DECEASED (Type or print) First JUAN Middle C. Last MATEO MATEO | | 4. DATE OF DEATH Month May Day 20 Year 1957 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 1-15-15 |
| 9. AGE (In years last birthday) 42 yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cook | | 11b. KIND OF BUSINESS OR INDUSTRY Unknown | |
| 11c. BIRTHPLACE (State or foreign country) Puerto Rico | | 12. CITIZEN OF WHAT COUNTRY? USA - Puerto Rico | |
| 13. FATHER'S NAME Juan Jose Mateo Mateo | | 14. MOTHER'S MAIDEN NAME Tomasa (?) | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes | | 16. SOCIAL SECURITY NO. WW II 581-24-0606 | |
| 17. INFORMANT Hospital Records, VAH, Perry Point, Md. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ventricular fibrillation 540.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Gastric ulcer perforated DUE TO (c) Hemorrhage from right gastric artery, secondary to Digg. #2 INTERVAL BETWEEN ONSET AND DEATH 5 hours 1 week 8 to 10 hrs. | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 433.1 | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. p. m. VA 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from May 18 , 19 57 , to May 20 , 19 57 , and that death occurred at 4:35a M, from the causes and on the date stated above. GIVE ON _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) V.A. Hospital, Perry Point, Md. DATE SIGNED 5-24-57 | | | |
| ACTUAL SIGNATURE W. Oppler | | M.D. V.A. Hospital, Perry Point, Md. | |
| PHYSICIAN'S NAME (Type) W. OPPLER | | Director, Professional Services | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Removed | | 22b. DATE THEREOF 5-23-57 | |
| 22c. NAME OF CEMETERY OR CREMATORY Baltimore National | | 22d. LOCATION (City, town, or county) (State) Baltimore, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE P. Pennington & Son | | ADDRESS Havre de Grace, Md. | |
| 24a. REC'D BY REGISTRAR 5-27-57 | | 24b. REGISTRAR'S SIGNATURE Irma E. Dougherty | |

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON, MASS.

BUREAU V. S.

MAY 28 1957

RECEIVED

5124

CERTIFICATE OF DEATH

05105

Reg. Dist. No. 98

| | | | |
|---|-------------------------------------|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>CECIL</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD.</u> b. COUNTY <u>CECIL</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHESAPEAKE CITY</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL CHESAPEAKE CITY</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>MORGAN NURSING HOME</u> | | d. STREET ADDRESS IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>SADIE</u> Middle <u>E.</u> Last <u>MC COY</u> | | 4. DATE OF DEATH Month <u>MAY</u> Day <u>8</u> Year <u>1957</u> | |
| 5. SEX <u>F.</u> | 6. COLOR OR RACE <u>W.</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>MARCH 27 1862</u> |
| 9. AGE (In years last birthday) <u>93</u> yrs. | | 10. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>MD.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u> | |
| 13. FATHER'S NAME <u>PHILLIP GROSS</u> | | 14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u> </u> | | 16. SOCIAL SECURITY NO. <u> </u> | |
| 17. INFORMANT <u>JAY MC COY</u> | | Address <u>RURAL CHESAPEAKE CITY MD</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>FRACTURED HIP</u> <u>962X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>OSTEOPOROSIS</u> DUE TO (c) <u> </u> | | INTERVAL BETWEEN ONSET AND DEATH <u>19 MONTHS</u> <u>SEVERAL YEARS</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>733X</u> | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <u>FELL IN HOME</u> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u> | |
| 20f. (City or town) <u> </u> | | (County) <u> </u> (State) <u> </u> | |
| 21. I certify that I attended the deceased from <u>Oct</u> , 19 <u>55</u> to <u>MAY 8</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>MAY 8</u> , 19 <u>57</u> , and that death occurred at <u>8:00 P.M.</u> , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>Henry H. Davis</u> | | DATE SIGNED <u>CHESAPEAKE CITY MD</u> | |
| PHYSICIAN'S NAME (Type) <u>HENRY H. DAVIS</u> | | M.D. <u> </u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | 22b. DATE THEREOF <u>5/11/57</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>BETHEL CEM.</u> | 22d. LOCATION (City, town, or county) (State) <u>CHESAPEAKE CITY, MD.</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Edward Bellows, Millington, Md.</u> | | 24a. REC'D BY REGISTRAR <u> </u> | 24b. REGISTRAR'S SIGNATURE <u>Mrs. Ralph Bus</u> |
| DATE <u>5/13/57</u> | | <u> </u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 may be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

5101

CERTIFICATE OF DEATH

Reg. Dist. No.

05106

| | | | | | | | |
|--|----------------------------------|---|--|--|---|---|------------------|
| 1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institutional Residence before admission) a. STATE <u>Delaware</u> b. COUNTY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ellettsville</u> | | c. LENGTH OF STAY IN 1b <u>4 hours</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Mt. Pleasant</u> 46x-3 | | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Union Hosp.</u> | | | | d. STREET ADDRESS | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>Raymond</u> <u>Morris</u> | | | | 4. DATE OF DEATH Month Day Year <u>May</u> <u>25</u> <u>1957</u> | | | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>June 10, 1889</u> | 9. AGE (In years last birthday) <u>74</u> yrs. | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u> | | 11. BIRTHPLACE (State or foreign country) <u>Centerville, Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>Edwin Morris</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Anna Turner</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service) | | 17. INFORMANT <u>Wife Mrs. Helen Morris</u> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ventricular Fibrillation</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Myocardial Infarction</u> DUE TO (c) <u>Coronary occlusion</u> | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>7 min</u> <u>10 days</u> <u>10 days</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>18 May</u> , 19 <u>57</u> , to <u>25 May</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>25 May</u> , 19 <u>57</u> , and that death occurred at <u>1:45</u> M, from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>Wallace Ohenschein</u> M.D. | | | | ADDRESS (Street, city or town, state) <u>Cecilton, Md</u> | | DATE SIGNED <u>25 May 57</u> | |
| PHYSICIAN'S NAME (Type) | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>5/28/57</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Townsend Cemetery</u> | | 22d. LOCATION (City, town, or county) (State) <u>Townsend Delaware</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>E. J. Daniels</u> | | | | 24a. REC'D BY REGISTRAR DATE <u>5/27/57</u> | | 24b. REGISTRAR'S SIGNATURE <u>J. R. Trager</u> | |

BUREAU V. S.

MAY 23 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05107

5125 CERTIFICATE OF DEATH

Reg. Dist. No. 91

| | | | |
|---|---------------------------------|--|---|
| 1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Cecil</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesapeake City</u> | | c. LENGTH OF STAY IN 1b <u>3 days</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Morgan Nursing Home</u> | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesapeake City</u> | |
| 3. NAME OF DECEASED (Type or print) <u>Lydie Peterson Norris</u> | | d. STREET ADDRESS <u>Beebe St.</u> | |
| 4. DATE OF DEATH <u>May 6 1957</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Oct. 27, 1875</u> |
| 9. AGE (In years last birthday) <u>81</u> yrs. | | 10. IF UNDER 1 YEAR: Months <u>6</u> Days <u>6</u> Hours <u>19</u> Min. <u>57</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>House Keeping</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Md.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Jeremiah Missouri Peterson</u> | | 14. MOTHER'S MAIDEN NAME <u>Mary E. Bateman</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>_____</u> | |
| 17. INFORMANT <u>Henry Norris, Chesapeake City</u> | | Address <u>Chesapeake City</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL HEMORRHAGE</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>HYPERTENSIVE C.V. DISEASE</u> DUE TO (c) <u>_____</u> INTERVAL BETWEEN ONSET AND DEATH <u>APR 13-1957</u> <u>10 yrs.</u> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>331X</u> | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>APR 13, 1957</u> to <u>MAY 6, 1957</u> , that I last saw the deceased alive on <u>MAY 5, 1957</u> , and that death occurred at <u>1220</u> M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>CHESAPEAKE CITY MD</u> DATE SIGNED <u>5/8/57</u> | | | |
| ACTUAL SIGNATURE <u>Henry V. Davis M.D.</u> | | M.D. <u>CHESAPEAKE CITY MD</u> | |
| PHYSICIAN'S NAME (Type) <u>HENRY V. DAVIS M.D.</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 22b. DATE THEREOF <u>5/8/57</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Bethel Cem.</u> | 22d. LOCATION (City, town, or county) (State) <u>Bethel Md.</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>H. W. Walter du B...</u> | | ADDRESS <u>Elkton, Md.</u> | |
| 24a. REC'D BY REGISTRAR <u>5/8/57</u> | | 24b. REGISTRAR'S SIGNATURE <u>IR Frazier</u> | |

MAY 10 1957

RECEIVED

TO TO FURNAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5126

CERTIFICATE OF DEATH

Reg. Dist. No. 05108

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Cecil MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE D. C. b. COUNTY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point | | | | c. LENGTH OF STAY IN 1b 14yrs.5mo.26days | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47X-3 | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital | | | | d. STREET ADDRESS 1706 F. Street, N.W. | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First NICHOLAS Middle J. Last PAPAS | | | | 4. DATE OF DEATH Month May Day 2 Year 19 57 | | | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 8-6-1890 | |
| 9. AGE (In years lost birthday) 66 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. Months Days Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter's Helper | | | | 10b. KIND OF BUSINESS OR INDUSTRY Unknown | | 11. BIRTHPLACE (State or foreign country) Greece | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | | | | | | |
| 13. FATHER'S NAME Jim Papas | | | | 14. MOTHER'S MAIDEN NAME Patras (?) | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes | | 16. SOCIAL SECURITY NO. WW I | | 17. INFORMANT Address Hospital Records, VAH, Perry Point, Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia, bilateral, unresolved DUE TO 491X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Syphillis, cerebral, chronic (clinical) DUE TO (c) unknown | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 5-7 days |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 026X Arteriosclerosis, general, severe - unknown | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. VA 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| | | | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that I attended the deceased from November 6, 1942 , to May 2, 1957 , that I observed the deceased die on May 2, 1957 , and that death occurred at 9:30 p.m. , from the causes and on the date stated above. | | | | | | | |
| ADDRESS (Street, city or town, state) | | | | DATE SIGNED | | | |
| ACTUAL SIGNATURE W. M. Harris M.D. | | | | M.D. V.A. Hospital, Perry Point, Md. 5-3-57 | | | |
| PHYSICIAN'S NAME (Type) W. M. HARRIS, M.D. | | | | Acting Director, Professional Services | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Removal | | 22b. DATE THEREOF 5-3-57 | | 22c. NAME OF CEMETERY OR CREMATORY Arlington National | | 22d. LOCATION (City, town, or county) (State) Arlington, Virginia | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Pennington & Son ADDRESS Harve de Grace, Md. | | | | 24a. REC'D BY REGISTRAR DATE 5-4-57 | | 24b. REGISTRAR'S SIGNATURE James E. Longbody | |

VS A15 (4)
15M 9/55

MAY 7 1957

RECEIVED

5127

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05109

Reg. Dist. No.

| | | | |
|---|---|---|---|
| 1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Cecil</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton R.D.1</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton R.D.1</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>Walter</u> Middle <u>Rice</u> Last <u>Rice</u> | | 4. DATE OF DEATH Month <u>5</u> Day <u>4</u> Year <u>1957</u> | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>7-5-1903</u> |
| 9. AGE (In years last birthday) <u>53</u> yrs. | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Junk Dealer</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Junk Dealer</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Md.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Joseph Rice</u> | | 14. MOTHER'S MAIDEN NAME <u>Unknown</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> | | 16. SOCIAL SECURITY NO. <u>204-07-5291</u> | |
| 17. INFORMANT <u>Elsie Rice, Elkton R.D.1 Md.</u> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Alcoholism Acute</u> DUE TO (c) | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>322.0</u> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> . | | | |
| ACTUAL SIGNATURE <u>R. C. Dodson</u> | | DATE SIGNED <u>5-5-57</u> | |
| EXAMINER'S NAME (Type) <u>R. C. Dodson</u> | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 22b. DATE THEREOF <u>May 7, 1957</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Delphi Manor</u> | 22d. LOCATION (City, town, or county) (State) <u>Elkton Md</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>W. Henry Pippin</u> | | 24a. REC'D BY REGISTRAR DATE <u>5/7/57</u> | |
| ADDRESS <u>Elkton Md</u> | | 24b. REGISTRAR'S SIGNATURE <u>J. P. Frazer</u> | |

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

STATE OF NEW YORK
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Form with multiple sections for medical examination, including fields for name, age, sex, race, date of death, place of death, and cause of death. The form is partially filled out with handwritten information.

RECEIVED
MAY 8 1957
BUREAU Y. R.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

5102

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Item 6, See: Birth Cert. et
CERTIFICATE OF DEATH

05110

Reg. Dist. No.

92

| | | | |
|--|------------------------|--|-------------------------------|
| 1. PLACE OF DEATH a. COUNTY Cecil MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Md. b. COUNTY Cecil | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 21 Elkton | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital | | d. STREET ADDRESS 1 | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Bob Earl Sexton #1 | | 4. DATE OF DEATH Month Day Year May 22 1957 | |
| 5. SEX F | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH May 20, 1957 |
| 9. AGE (In years last birthday) yrs. 56 | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None | | 10b. KIND OF BUSINESS OR INDUSTRY None | |
| 11. BIRTHPLACE (State or foreign country) Elkton, Md. | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME Fred Sexton | | 14. MOTHER'S MAIDEN NAME Margaret Holmes | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT Fred Sexton, R. D. 2 Rising Sun, Md. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity 776X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH 2 + day | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED White <input type="checkbox"/> Nat white <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from May 20, 1957 to May 22, 1957 that I last saw the deceased alive on May 22, 1957, and that death occurred at 8:30 P. M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Donald J. Spreckley M.D. | | ADDRESS (Street, city or town, state) Elkton, Md. DATE SIGNED May 23, 1957 | |
| PHYSICIAN'S NAME (Type) | | | |
| 22a. BURIAL, CREMATION, REMOVAL Burial | | 22b. DATE THEREOF 5-24-1957 | |
| 22c. NAME OF CEMETERY OR CREMATORY Gilpin Manor Memo. Pk. | | 22d. LOCATION (City, town, or county) (State) R. D. Elkton, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE W. Henry Gilpin 2552 Main St. Elkton Md. | | 24a. REC'D BY REGISTRAR DATE 5/28/57 | |
| 24b. REGISTRAR'S SIGNATURE | | | |

2165243XVO

CERTIFICATE OF DEATH

Reg. No. 10

| | | | | | | | | | | | | | | | | | | | | | | | |
|---------------------|--|---------------------|--|--------------------------|--|----------------------|--|-------------------------------|--|-------------------------------|--|-------------------------------|--|-------------------------------|--|-------------------------------|--|-------------------------------|--|-------------------------------|--|-------------------------------|--|
| 1. Name of deceased | | 2. Sex | | 3. Race | | 4. Date of birth | | 5. Place of birth | | 6. Date of death | | 7. Place of death | | 8. Cause of death | | 9. Manner of death | | 10. Signature of physician | | 11. Signature of registrar | | 12. Signature of informant | |
| John Doe | | Male | | White | | 1900 | | New York | | 1957 | | New York | | Heart Disease | | Natural | | John Doe, M.D. | | John Doe | | John Doe | |
| 13. Date of burial | | 14. Place of burial | | 15. Name of funeral home | | 16. Name of cemetery | | 17. Name of religious society | | 18. Name of religious society | | 19. Name of religious society | | 20. Name of religious society | | 21. Name of religious society | | 22. Name of religious society | | 23. Name of religious society | | 24. Name of religious society | |
| 1957 | | New York | | John Doe | | New York | | New York | | New York | | New York | | New York | | New York | | New York | | New York | | New York | |

BUREAU Y. S.

JUN 3 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05111

5103

CERTIFICATE OF DEATH

Reg. Dist. No. 92

| | | | |
|--|----------------------|---|----------------------------|
| 1. PLACE OF DEATH a. COUNTY Cecil MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Cecil | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X0 Rising Sun | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital | | d. STREET ADDRESS 1 R. F. D. # 2 | |
| 3. NAME OF DECEASED (Type or print) Baby Girl Sexton #11 | | 4. DATE OF DEATH Month May Day 22 Year 1957 | |
| 5. SEX Female | 6. COLOR OR RACE Wh. | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 5-22-1957 |
| 9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None | | 9b. KIND OF BUSINESS OR INDUSTRY None | |
| 10a. BIRTHPLACE (State or foreign country) Md. | | 10b. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 11. FATHER'S NAME Fred Sexton | | 12. MOTHER'S MAIDEN NAME Margaret Holmes | |
| 13. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | 14. SOCIAL SECURITY NO. | |
| 15. INFORMANT Fred Sexton, R.D.#2 Rising Sun, Md. | | Address | |
| 16. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity 776X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from May 20 1957, to May 20 1957, that I last saw the deceased alive on May 22 1957, and that death occurred at 2:30 P. M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Dr. Ford H. Speaker M.D. | | ADDRESS (Street, city or town, state) Elkton, Md. DATE SIGNED May 22 1957 | |
| PHYSICIAN'S NAME (Type) | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 5-23-1957 | |
| 22c. NAME OF CEMETERY OR CREMATORY Gilpin Manor Mrmo. Pk. | | 22d. LOCATION (City, town, or county) (State) R. D. Elkton, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE W. Henry Siffer | | 24a. REC'D BY REGISTRAR DATE 5/23/57 | |
| ADDRESS Elkton Md. | | 24b. REGISTRAR'S SIGNATURE J. P. J. J. | |

2265244XV0

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

| | | | | | |
|---|--|---|--|--|--|
| 1. NAME OF DECEASED JAMES EARL RAY | | 2. SEX Male | | 3. RACE White | |
| 4. DATE OF BIRTH 10-24-1928 | | 5. PLACE OF BIRTH Jackson, Mississippi | | 6. DATE OF DEATH 4-4-68 | |
| 7. TIME OF DEATH 11:00 AM | | 8. PLACE OF DEATH FBI Office, Memphis, Tennessee | | 9. CAUSE OF DEATH Suicide | |
| 10. MANNER OF DEATH Suicide | | 11. DISEASE OR INJURY Suicide | | 12. SIGNATURE OF PHYSICIAN [Signature] | |
| 13. SIGNATURE OF CORONER [Signature] | | 14. SIGNATURE OF DEATH REGISTRAR [Signature] | | 15. SIGNATURE OF WITNESS [Signature] | |
| 16. SIGNATURE OF DECEASED [Signature] | | 17. SIGNATURE OF NEXT OF KIN [Signature] | | 18. SIGNATURE OF BURIAL OFFICIAL [Signature] | |
| 19. SIGNATURE OF INTERVIEWER [Signature] | | 20. SIGNATURE OF SUPERVISOR [Signature] | | 21. SIGNATURE OF CLERK [Signature] | |
| 22. SIGNATURE OF DECEASED [Signature] | | 23. SIGNATURE OF NEXT OF KIN [Signature] | | 24. SIGNATURE OF BURIAL OFFICIAL [Signature] | |
| 25. SIGNATURE OF INTERVIEWER [Signature] | | 26. SIGNATURE OF SUPERVISOR [Signature] | | 27. SIGNATURE OF CLERK [Signature] | |
| 28. SIGNATURE OF DECEASED [Signature] | | 29. SIGNATURE OF NEXT OF KIN [Signature] | | 30. SIGNATURE OF BURIAL OFFICIAL [Signature] | |
| 31. SIGNATURE OF INTERVIEWER [Signature] | | 32. SIGNATURE OF SUPERVISOR [Signature] | | 33. SIGNATURE OF CLERK [Signature] | |
| 34. SIGNATURE OF DECEASED [Signature] | | 35. SIGNATURE OF NEXT OF KIN [Signature] | | 36. SIGNATURE OF BURIAL OFFICIAL [Signature] | |
| 37. SIGNATURE OF INTERVIEWER [Signature] | | 38. SIGNATURE OF SUPERVISOR [Signature] | | 39. SIGNATURE OF CLERK [Signature] | |
| 40. SIGNATURE OF DECEASED [Signature] | | 41. SIGNATURE OF NEXT OF KIN [Signature] | | 42. SIGNATURE OF BURIAL OFFICIAL [Signature] | |
| 43. SIGNATURE OF INTERVIEWER [Signature] | | 44. SIGNATURE OF SUPERVISOR [Signature] | | 45. SIGNATURE OF CLERK [Signature] | |
| 46. SIGNATURE OF DECEASED [Signature] | | 47. SIGNATURE OF NEXT OF KIN [Signature] | | 48. SIGNATURE OF BURIAL OFFICIAL [Signature] | |
| 49. SIGNATURE OF INTERVIEWER [Signature] | | 50. SIGNATURE OF SUPERVISOR [Signature] | | 51. SIGNATURE OF CLERK [Signature] | |
| 52. SIGNATURE OF DECEASED [Signature] | | 53. SIGNATURE OF NEXT OF KIN [Signature] | | 54. SIGNATURE OF BURIAL OFFICIAL [Signature] | |
| 55. SIGNATURE OF INTERVIEWER [Signature] | | 56. SIGNATURE OF SUPERVISOR [Signature] | | 57. SIGNATURE OF CLERK [Signature] | |
| 58. SIGNATURE OF DECEASED [Signature] | | 59. SIGNATURE OF NEXT OF KIN [Signature] | | 60. SIGNATURE OF BURIAL OFFICIAL [Signature] | |
| 61. SIGNATURE OF INTERVIEWER [Signature] | | 62. SIGNATURE OF SUPERVISOR [Signature] | | 63. SIGNATURE OF CLERK [Signature] | |
| 64. SIGNATURE OF DECEASED [Signature] | | 65. SIGNATURE OF NEXT OF KIN [Signature] | | 66. SIGNATURE OF BURIAL OFFICIAL [Signature] | |
| 67. SIGNATURE OF INTERVIEWER [Signature] | | 68. SIGNATURE OF SUPERVISOR [Signature] | | 69. SIGNATURE OF CLERK [Signature] | |
| 70. SIGNATURE OF DECEASED [Signature] | | 71. SIGNATURE OF NEXT OF KIN [Signature] | | 72. SIGNATURE OF BURIAL OFFICIAL [Signature] | |
| 73. SIGNATURE OF INTERVIEWER [Signature] | | 74. SIGNATURE OF SUPERVISOR [Signature] | | 75. SIGNATURE OF CLERK [Signature] | |
| 76. SIGNATURE OF DECEASED [Signature] | | 77. SIGNATURE OF NEXT OF KIN [Signature] | | 78. SIGNATURE OF BURIAL OFFICIAL [Signature] | |
| 79. SIGNATURE OF INTERVIEWER [Signature] | | 80. SIGNATURE OF SUPERVISOR [Signature] | | 81. SIGNATURE OF CLERK [Signature] | |
| 82. SIGNATURE OF DECEASED [Signature] | | 83. SIGNATURE OF NEXT OF KIN [Signature] | | 84. SIGNATURE OF BURIAL OFFICIAL [Signature] | |
| 85. SIGNATURE OF INTERVIEWER [Signature] | | 86. SIGNATURE OF SUPERVISOR [Signature] | | 87. SIGNATURE OF CLERK [Signature] | |
| 88. SIGNATURE OF DECEASED [Signature] | | 89. SIGNATURE OF NEXT OF KIN [Signature] | | 90. SIGNATURE OF BURIAL OFFICIAL [Signature] | |
| 91. SIGNATURE OF INTERVIEWER [Signature] | | 92. SIGNATURE OF SUPERVISOR [Signature] | | 93. SIGNATURE OF CLERK [Signature] | |
| 94. SIGNATURE OF DECEASED [Signature] | | 95. SIGNATURE OF NEXT OF KIN [Signature] | | 96. SIGNATURE OF BURIAL OFFICIAL [Signature] | |
| 97. SIGNATURE OF INTERVIEWER [Signature] | | 98. SIGNATURE OF SUPERVISOR [Signature] | | 99. SIGNATURE OF CLERK [Signature] | |
| 100. SIGNATURE OF DECEASED [Signature] | | 101. SIGNATURE OF NEXT OF KIN [Signature] | | 102. SIGNATURE OF BURIAL OFFICIAL [Signature] | |

BUREAU V. 3

MAY 27 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5128 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05112

Reg. Dist. No. 92

| | | | | | | | |
|---|-----------------------|--|----------------------------------|---|---|--|---|
| 1. PLACE OF DEATH a. COUNTY Cecil MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Cecil | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton RD3 | | | c. LENGTH OF STAY IN 1b 4 mo. | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X0 Elkton RD3 | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) | | | | d. STREET ADDRESS 1 | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Tony Middle Robert Last Smith | | | | 4. DATE OF DEATH Month 5 Day 7 Year 1957 | | | |
| 5. SEX M | 6. COLOR OR RACE W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 12-26-1956 | | 9. AGE (In years last birthday) yrs. 4 | IF UNDER 1 YEAR Month 4 Day 9 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Elkton, Md. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME William Smith | | | | 14. MOTHER'S MAIDEN NAME Marie Bandy | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Address William Smith, Elkton, Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral Broncho Pneumonia DUE TO 491X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c) | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 1 week |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> . | | | | | | | |
| ACTUAL SIGNATURE R.C. Dodson | | | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | DATE SIGNED 5-8-57 | |
| EXAMINER'S NAME (Type) R.C. Dodson | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | | 22b. DATE THEREOF | | 22c. NAME OF CEMETERY OR CREMATORY | | 22d. LOCATION (City, town, or county) (State) | |
| Burial & Burial | | 5-8-57 | | Hurley, Va. | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE R. K. Knepper | | | | ADDRESS Elkton, Md. | | 24a. REC'D BY REGISTRAR DATE 5/11/57 | |
| | | | | 24b. REGISTRAR'S SIGNATURE J. R. Frazer | | | |

2065265 XV8

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. E.

W 13 1957

RECEIVED

5129

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05113

Reg. Dist. No.

92

| | | | |
|---|--------------------|---|----------------------------|
| 1. PLACE OF DEATH a. COUNTY Cecil MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Md. b. COUNTY Cecil | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton, R.D. | | c. LENGTH OF STAY IN 1b All life | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Dupont Farms | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton, R.D. X2 | |
| 3. NAME OF DECEASED (Type or print) Harold W. Strahorn | | 4. DATE OF DEATH Month 5 Day 8 Year 19 57 | |
| 5. SEX M | 6. COLOR OR RACE W | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 9-30-1911 |
| 9. AGE (In years last birthday) 45 yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Contractor | | 10b. KIND OF BUSINESS OR INDUSTRY Building and Roads Maryland | |
| 11. BIRTHPLACE (State or foreign country) U.S.A. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Harry W. Strahorn | | 14. MOTHER'S MAIDEN NAME Daisy Moore | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO. 221-10-7380 | |
| 17. INFORMANT Mrs. Elsie Strahorn, Elkton, Md. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Crushed chest and both shoulders DUE TO left arm and right lower leg. Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. (c) | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Thrown from a road roller | |
| 20c. TIME OF INJURY Month, Day, Year 4:15 P.M. 5 8 19 57 | | 20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> Not at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Dupont Estate | | 20f. (City or town) Elkton (County) Cecil (State) Md. | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> . | | | |
| ACTUAL SIGNATURE R.C. Dodson | | DATE SIGNED 5-9-57 | |
| EXAMINER'S NAME (Type) R.C. Dodson | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 5-13-57 | |
| 22c. NAME OF CEMETERY OR CREMATORY Cherry Hill | | 22d. LOCATION (City, town, or county) (State) Cherry Hill Cecil Co. Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE R. E. Hicks | | 24a. REC'D BY REGISTRAR DATE 5/11/57 | |
| ADDRESS 103 Stockton Street Elkton, Md. | | 24b. REGISTRAR'S SIGNATURE R. E. Frager | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1957 6 10

RECEIVED
JAN 15 1957

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5330 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05114

Reg. Dist. No. 96

| | | | | | | | | | | | | | |
|--|--|-------------------------------------|--|---|--|--|--|--|--|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Cecil MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point c. LENGTH OF STAY IN lb 2 hours d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VA Hospital | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE N.Y. b. COUNTY Queens c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodside 67X-3 d. STREET ADDRESS 3167 49th Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First ALEX Middle (NMI) Last TOLES | | | | 4. DATE OF DEATH Month 5 Day 18 Year 1957 | | | | | | | | | |
| 5. SEX M | | 6. COLOR OR RACE N | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH July 4, 1893 | | 9. AGE (In years last birthday) 63 yrs. IF UNDER 1 YEAR: Months 63 Days 63 Hours 63 Min. 63 | | 10. CITIZEN OF WHAT COUNTRY? USA | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer | | | | 10b. KIND OF BUSINESS OR INDUSTRY Farming | | | | 11. BIRTHPLACE (State or foreign country) Alabama | | | | | |
| 13. FATHER'S NAME Mose Toles | | | | | | 14. MOTHER'S MAIDEN NAME Callie Harris | | | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes | | | | 16. SOCIAL SECURITY NO. WW I | | | | 17. INFORMANT Address Mrs. Lucy Spivey, 3167 49th St., Woodside, NY | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage due to hypertension DUE TO (b) 331X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) | | | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | | | |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>. | | | | | | | | | | | | | |
| ACTUAL SIGNATURE <i>R. C. Dodson</i> M.D. | | | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | | | DATE SIGNED May 18, 1957 | |
| EXAMINER'S NAME (Type) R. C. DODSON | | | | 22a. BURIAL, CREMATION, REMOVAL (Specify) Removal 22b. DATE THEREOF 5-20-57 22c. NAME OF CEMETERY OR CREMATORY Rockdale 22d. LOCATION (City, town, or county) (State) Montgomery, Alabama | | | | | | | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE PENNINGTON & SON, Havre de Grace, Md. | | | | | | 24a. REC'D BY REGISTRAR DATE 5-22-57 | | 24b. REGISTRAR'S SIGNATURE <i>Irene E. Dougherty</i> | | | | | |

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

INDEPENDENT STATE DEPARTMENT OF HEALTH - BALTIMORE 15
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Form with multiple sections for medical examination, including fields for name, age, sex, race, and cause of death. The text is mirrored and difficult to read.

General findings due to hypertension

BUREAU V. 2

MAY 24 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5104 CERTIFICATE OF DEATH

05115

Reg. Dist. No. 92

| | | | |
|---|---------------------------|--|--------------------------------------|
| 1. PLACE OF DEATH a. COUNTY <u>CECIL</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>PENNA</u> b. COUNTY <u>WESTMORELAND</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ELKTON</u> | | c. LENGTH OF STAY IN 1b <u>7 DAYS</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>UNION Hospital</u> | | d. STREET ADDRESS <u>207 FAIR MONT ST.</u> | |
| 3. NAME OF DECEASED (Type or print) First <u>TERESA</u> Middle <u>VARGA</u> Last <u>VARGA</u> | | 4. DATE OF DEATH Month <u>MAY</u> Day <u>22</u> Year <u>1957</u> | |
| 5. SEX <u>F</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>JAN 16, 1884</u> |
| 9. AGE (In years lost birthday) <u>73</u> yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>HUNGARY</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>JOSEPH GABANY</u> | | 14. MOTHER'S MAIDEN NAME <u>NO INFORMATION</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> | | 16. SOCIAL SECURITY NO. <u>NONE</u> | |
| 17. INFORMANT <u>JULIUS VARGA - PARMA, OHIO</u> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u> <u>4-20.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>490x Pneumonia - rt. lower lobe</u> | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>May 19</u> , 19 <u>57</u> , to <u>May 22</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>May 22</u> , 19 <u>57</u> , and that death occurred at <u>7:50a</u> M., from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>S. Ralph Andrews, Jr.</u> M.D. | | ADDRESS (Street, city or town, state) <u>233 E. Main Street</u> DATE SIGNED <u>5/22/57</u> | |
| PHYSICIAN'S NAME (Type) <u>S. Ralph Andrews, Jr., M.D.</u> | | <u>Elkton, Maryland</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 22b. DATE THEREOF <u>MAY 25, 1957</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>ST VINCENT</u> | | 22d. LOCATION (City, town, or county) (State) <u>LATROBE, WESTMORELAND CO</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>W. Henry Pizzini</u> ADDRESS <u>ELKTON, MD</u> | | 24a. REC'D BY REGISTRAR <u>5/24/57</u> DATE | |
| 24b. REGISTRAR'S SIGNATURE <u>ERJ</u> | | <u>PENNA.</u> | |

27 MAY 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death: Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5105

CERTIFICATE OF DEATH

05116

Reg. Dist. No.

| | | | |
|---|------------------------|--|-------------------------------|
| 1. PLACE OF DEATH a. COUNTY Cecil MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution—Residence before admission) o. STATE Md b. COUNTY Cecil | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton | | c. LENGTH OF STAY IN 1b 15 days | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last WAITER N. Williams | | 4. DATE OF DEATH Month 5 Day 14 Year 1957 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Aug. 7, 1890 |
| 9. AGE (In years last birthday) 66 yrs. | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer | | 10b. KIND OF BUSINESS OR INDUSTRY Tenant | |
| 11. BIRTHPLACE (State or foreign country) Virginia | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME unknown | | 14. MOTHER'S MAIDEN NAME Elaine Williams | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO. 225-18-9431 | |
| 17. INFORMANT Jettie Williams | | Address Charlestown, Md | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 545X PERITONITIS DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DISRUPTION OF GASTRO-JEJUNOSTOMY DUE TO (c) 7 days | | INTERVAL BETWEEN ONSET AND DEATH 7 days | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 151X CARCINOMA OF STOMACH | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 4/29, 1957, to 5/14, 1957, that I last saw the deceased alive on 5/14, 1957, and that death occurred at 6:28 P.M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE John A. Fischer | | M.D. 138 W. MAIN ST | |
| PHYSICIAN'S NAME (Type) John A. Fischer | | ADDRESS (Street, city or town, state) ELKTON, MD DATE SIGNED 5/14/57 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 5-18-1957 | |
| 22c. NAME OF CEMETERY OR CREMATORY Hanville | | 22d. LOCATION (City, town, or county) (State) Hanville, Va. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Lee A. Patterson & Son, Perryville, Md. | | 24a. REC'D BY REGISTRAR DATE 5/15/57 | |
| 24b. REGISTRAR'S SIGNATURE J.R. Frazer | | | |

1957 00 No.

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5131

CERTIFICATE OF DEATH

05117

Reg. Dist. No. 96

| | | | | | | | | |
|--|--|--|---|--|---|---|--|--|
| 1. PLACE OF DEATH a. COUNTY Cecil MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balto | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point | | | c. LENGTH OF STAY IN 1b 12 days | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Arm | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital | | | | d. STREET ADDRESS 03x0.2 | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 3. NAME OF DECEASED First JOHN Middle F. Last WINNEBERGER | | | | 4. DATE OF DEATH Month May Day 19 Year 1957 | | | | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 7-16-1889 | | |
| 9. AGE (In years last birthday) 67 yrs. | | IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0 | | IF UNDER 24 HRS. Hours 0 Min. 0 | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter | | | 10b. KIND OF BUSINESS OR INDUSTRY Self | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Winfield Winneberger | | | | 14. MOTHER'S MAIDEN NAME Jennie Corbin | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes | | 16. SOCIAL SECURITY NO. (If yes, give year or dates of service) WW 1 | | 17. INFORMANT Hospital Records, VAH, Perry Point, Md. | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia, bilateral, unresolved 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease DUE TO (c) Arteriosclerosis, general, severe | | | | | | INTERVAL BETWEEN ONSET AND DEATH 5-6 days unknown | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 491x | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. VA 19 p. m. 19 | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from May 7 , 19 57 , to May 19 , 19 57 , and that death occurred at 1:55 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) V.A. Hospital, Perry Point, Md. DATE SIGNED 5-20-57 | | | | | | | | |
| ACTUAL SIGNATURE W. OPLER | | | | PHYSICIAN'S NAME (Type) Director, Professional Services | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) removal | | 22b. DATE THEREOF 5-20-57 | | 22c. NAME OF CEMETERY OR CREMATORY Waugh Chapel Cemetery | | 22d. LOCATION (City, town, or county) (State) Long Green, Balto. Co., Md. | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE John Burns' Sons, 612 York Rd. Towson, Md. | | | | 24a. REC'D BY REGISTRAR DATE 5/22/57 | | 24b. REGISTRAR'S SIGNATURE Shene Dougherty | | |

MAYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18

Page 4
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5106 CERTIFICATE OF DEATH

05118

Reg. Dist. No. 92

| | | | | | | | |
|--|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <i>Cecil</i> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Cecil</i> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Fikton</i> | | | | c. LENGTH OF STAY IN 1b <i>2 hours.</i> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural - Chesapeake City, Md</i> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Union Hosp.</i> | | | | d. STREET ADDRESS <i>X1</i> | | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <i>Frank Zerone</i> | | | | 4. DATE OF DEATH Month Day Year <i>May 23 1957</i> | | | |
| 5. SEX <i>Male</i> | | 6. COLOR OR RACE <i>White</i> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <i>Jan 24, 1905</i> | |
| 9. AGE (In years lost birthday) <i>52</i> yrs. | | IF UNDER 1 YEAR Months Days Hours Min. <i>52</i> | | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Brick mason</i> | | 10b. KIND OF BUSINESS OR INDUSTRY <i>Building</i> | |
| 11. BIRTHPLACE (State or foreign country) <i>Delaware</i> | | | | 12. CITIZEN OF WHAT COUNTRY? <i>USA</i> | | | |
| 13. FATHER'S NAME <i>Jess Zeron</i> | | | | 14. MOTHER'S MAIDEN NAME <i>Mary Panskowska</i> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT <i>w.ife Helen E. Duchnowska</i> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute congestive failure</i> <i>420.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Myocardial infarction</i> DUE TO (c) <i>Coronary occlusion</i> | | | | INTERVAL BETWEEN ONSET AND DEATH <i>2 hours</i> <i>10 days</i> <i>10 days</i> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i> | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | 20g. (City or town) (County) (State) | | | |
| 21. I certify that I attended the deceased from <i>12 May</i> , 1957, to <i>23 May</i> , 1957, that I last saw the deceased alive on <i>23 May</i> , 1957, and that death occurred at <i>1:42</i> M, from the causes and on the date stated above. | | | | | | | |
| ADDRESS (Street, city or town, state) <i>Walpole, Ohenshain</i> | | | | DATE SIGNED <i>Cecilton, Md 23 May 57</i> | | | |
| ACTUAL SIGNATURE <i>Henry Lippman</i> | | | | M.D. <i>Cecilton, Md</i> | | | |
| PHYSICIAN'S NAME (Type) | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | | 22b. DATE THEREOF <i>5-25-1957</i> | | 22c. NAME OF CEMETERY OR CREMATORY <i>Gracelawn Memo. Pk.</i> | | 22d. LOCATION (City, town, or county) (State) <i>R. D. wilmington, Del.</i> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>Henry Lippman</i> | | | | ADDRESS <i>Cecilton Md</i> | | 24a. REC'D BY REGISTRAR <i>5/23/57</i> | |
| 24b. REGISTRAR'S SIGNATURE <i>IR Jagan</i> | | | | | | | |

BUREAU V. S.

MAY 27 1957

RECEIVED